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by
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Relational and Motivational Factors
of Nursing Empowerment
in an Acute Care Hospital

by
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Abstract

The purpose of this study is to examine the difference in perceptions of the motivational and relational components of nursing empowerment between baccalaureate- and associate-prepared nurses employed in a medium-sized hospital in Iowa. All staff nurses working at least half time were invited to participate in the study. Twenty-one respondents are associated-prepared and fifteen are baccalaureate-prepared. In this descriptive study responses from a three-part tool developed by Becker (1989) consisting of the RN Growth and Development Survey, the Professional Practice Survey, and the Survey of Professional Practice Environment are analyzed using independent t tests. There is not a statically significant ($p < .05$) difference noted in perceptions based on educational preparation for the motivational or relational component of empowerment. In addition, the variables of age and experience are analyzed with no significant difference noted with age. However, there is a significant difference in responses from nurses with more than ten years of experience for both the motivational and relational components of empowerment. Future researchers should include both the motivational and relational components when identifying and implementing strategies to support nursing empowerment.

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Chapter I

INTRODUCTION

Purpose

The purpose of this study was to examine the difference in perceptions of the motivational and relational components of nursing empowerment between baccalaureate- and associate-prepared nurses employed in a medium-sized acute care hospital in the Midwest. This study compared the responses of registered nurses based on educational preparation in a variety of practice environments within one health care agency. Several practice settings within the same institution were used since the philosophy of nursing, staffing patterns, organizational structure, and the mission statement of the organization was consistent.

Numerous research studies have focused on entry-level preparation of the nurse as a factor influencing a variety of issues in nursing practice. A significant difference in responses to variables such as job satisfaction, autonomy, role stress, professionalism, and self-concept were noted based on educational preparation (Goldstein, 1980; Murray & Morris, 1982; Stewart-Dedmon, 1988).

The second purpose of this study was to replicate, in part, a study of nursing empowerment currently being

conducted by Becker. The study by Becker is intended to measure nursing empowerment over time, while the intent of this study was to measure nursing empowerment using a cross-sectional design (Becker, 1989).

The timeliness of this study was appropriate since current nursing literature frequently refers to empowerment issues and discusses empowerment as a possible strategy to address the nursing shortage (Iowa Tri-Council Summit Report, 1989; Crissman & Wolfe, 1989; LeRoy, 1986; Ash, 1988). The timing of this study also coincides with other research being conducted related to nursing empowerment (Becker, 1989).

Background

Empowerment is a topic heard more and more frequently within the nursing profession. Empowerment has been described as a factor related to job satisfaction, motivation, and self-esteem. Behaviors reflecting powerlessness and low self-esteem have contributed to many of the problems in nursing today; examples of problems include low morale, lack of autonomy, poor nursing image, nurse abuse, and the shortage of nurses (Kanter, 1979; Burke, 1986; Harrison, 1987; Conger, 1988; Crissman & Wolf, 1989; Becker, 1989).

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The relationships between nurses and physicians, nurses and administration, nurses and patients, nurses and nursing leaders, and between nurses and co-workers have also been influenced by empowerment. Empowerment at individual, unit, or organizational levels has been described as one factor influencing the ability to meet expected goals effectively and efficiently (Crissman & Wolf, 1989; Conger, 1988; Kanter, 1979).

Generally, theorists have described the construct of empowerment in one of two ways: either with a relational focus or with a motivational focus. Factors in the environment are the focus of the first group, while factors related to the individual's personal characteristics are the focus of the second group.

Empowerment as a relational construct addresses the relationships between more powerful or controlling individuals or groups and less powerful or controlling individuals or groups. It is believed that individuals or groups who have power will have a greater degree of success in influencing others and achieving desired outcomes. Examining environmental factors will provide insight into the relational construct of empowerment (Conger, 1988; Schermerhorn, 1982).

Boyle (1987) describes empowerment as the ability to utilize resources to achieve desired results. Knowledge is one of the most important resources

nursing has. As nurses recognize individual knowledge and expertise, increased consultation, collaboration, and collegiality among nurses can result in successful goal achievement. Nurses must be aware of power as a positive and effective force in promoting quality patient care (Bowman & Culpepper, 1974; Wynd, 1976).

The degree to which individuals or groups are able to describe their unique contribution, irreplaceability, and centrality in the health care system also depicts the relational focus of empowerment. Identifying and developing strategies to utilize vertical power (the influence or control one has over another) and horizontal power (the relationship between groups or subunits) serves to unify and empower the nursing profession (Stuart, 1986).

Inlander (1988) describes the relational focus of empowerment as the ability to use power and control to create a desirable work environment. Empowered individuals possess the necessary information and resources to function effectively.

Empowerment from a relational focus, then, becomes the process by which power is shared by the more powerful with the less powerful. A variety of management strategies deals with the relational construct of empowerment. Examples of management strategies include participative management, leadership

styles, delegation, decentralization, shared governance, and quality circles (Conger, 1988).

Empowerment from a motivational focus refers to the power or control individuals or groups have in influencing their world. The ability to cope with events, situations, and people increases an individual's sense of power. An inability to cope with the physical and emotional demands of the environment results in feelings of frustration and powerlessness (Conger, 1988).

Willey (1987) describes empowerment as the ability to have an impact on decisions that govern one's lifestyle. A clear identification of goals, a high degree of responsibility and accountability, and the ability to form alliances promote decision making and empowerment (Willey, 1987).

The ability of leaders to obtain and share resources, opportunities, and rewards with subordinates results in greater feelings of empowerment. Kanter (1983) studied leadership characteristics in a variety of social organizations in order to identify factors which separate successful from unsuccessful companies. Allowing employees to be involved in decision making and workplaces which stimulate employees to become innovative and empowered were characteristics noted among successful companies (Kanter, 1983).

Self-concept is an important motivational factor often considered when examining empowerment. Gecas (1986) describes the motivational components of self-concept as self-esteem, self-efficacy and authenticity. A sense of who one is, one's ability to interact within the environment to foster change and achieve goals, and one's sense of realness, significance, or meaningfulness leads to feelings of control and empowerment (Gecas, 1986; Cowden, 1978; Logan, 1985).

From a motivational focus, empowerment is related to the individual's need for self-determination and self-efficacy. Self-efficacy becomes a major motivational factor related to the individual's perception of self-as-cause. Efficacy expectations are associated with the belief that one can successfully perform the behavior required to produce an expected outcome. The development of competencies and personal effectiveness expectations leads to increased feelings of self-efficacy. (Knoop, 1981; Runyon, 1973; Blau, 1987; Frost, 1983, Bandura, 1986).

From a managerial or organizational standpoint, strategies that strengthen an individual's or group's feelings of self-determination or self-efficacy will result in an increased perception of power. Strategies that decrease the feeling of self-determination or self-efficacy will result in feelings of frustration

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and powerlessness.

From the relational viewpoint, empowerment becomes the process by which resources, information, authority, and opportunities are shared with or delegated to subordinates. Empowerment from a motivational standpoint becomes the process by which subordinates develop a strong sense of self-determination or self-efficacy.

The stereotypical image of nurses as the physician's handmaiden, dependent care givers, and unintellectual members of the health care team erodes the power base of nurses. Consumers must recognize nurses as competent, intelligent, independent and autonomous health care providers in order for nursing to be empowered (Nordhold, 1986; Peplau, 1985; Freidman, 1982).

A lack of empowerment or the inability to gain control over decisions in the workplace is evidenced as women leave nursing to branch out in areas of law, business, sales, and insurance. A greater control over the work environment is reported by women in areas of law, business, sales, and insurance than by women in nursing (Garant, 1981).

Nursing as a profession has often been viewed as lacking in power. Growth of professional power has been stymied by a number of factors. Economic factors

have had a major impact on influencing the role of the nurse. The role of the nurse has changed as the demand for health care services has fluctuated based on health care needs (i.e., war, epidemics, and aging population) and the number of available physicians and nurses. Economic factors and control of resources are often viewed as the force affecting change rather than the nursing profession causing the change (Ashley, 1975; Hendricks, 1982).

Nursing's lack of power has also been noted in the political setting. The historical perspective of nursing, the predominance of females in the profession, the subservient role of the nurse, nursing's lack of unification, and limited membership in professional organizations have further limited nursing empowerment (Kalisch & Kalisch, 1980; Ashley, 1975; Bowman, 1974; De Maio, 1979; Hendricks, 1982).

Definitions

Becker (1989) includes both environmental and individual characteristics as components in the definition of nursing empowerment. Nursing empowerment is described as the perceived point on a continuum from powerless, or the inability to influence others, change the work environment, and effectively perform job expectations to fully empowered or the ability to

influence others, change the work environment, and effectively perform job expectations.

In this study the definition of nursing empowerment includes both the relational and motivational factors. A nurse with relational empowerment has adequate information, resources, social supports, and autonomy in role performance. A nurse with motivational empowerment has a strong self-concept, including self-esteem, self-efficacy, and authenticity.

Empowerment was measured by scores on the Becker Empowerment tool. A score for perceptions related to the motivational component of empowerment was obtained from the Professional Practice Survey portion, and a score for perceptions related to the relational component of empowerment was obtained from the Survey of Professional Practice Environment portion.

For purposes of this study, entry-level education was defined as the basic educational preparation completed by the individual to prepare for registered nurse licensure. The types of educational preparation considered were baccalaureate degree and associate degree in nursing. Entry level was determined by subject self-response.

Assumptions

This research study was based on the following assumptions:

1. The individual nurse practitioner will benefit from empowerment in the work environment.
2. The health care organization will benefit from empowered nurses in the work force.
3. Empowerment of nurses will promote nursing as a profession.
4. The health care consumer will benefit from the empowerment of the nursing profession.

Hypotheses

The research hypotheses are as follows:

1. There will be a statistically significant difference in reported perceptions of the motivational or self concept component of nursing empowerment of the baccalaureate and the associate prepared nurse employed in an acute care setting.
2. There will be a statistically significant difference in reported perceptions of the relational or environmental component of nursing empowerment of the baccalaureate and the associate prepared nurse employed in an acute care setting.

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Null Hypotheses:

The null hypotheses are as follows:

1. There will not be a statistically significant difference in reported perceptions of the motivational component of nursing empowerment of the baccalaureate- and the associate-prepared nurse employed in an acute care setting.
2. There will not be a statistically significant difference in reported perceptions of the relational component of nursing empowerment of the baccalaureate- and the associate-prepared nurse employed in an acute care setting.

Research Questions

The research questions were nine in number and were related to the motivational and relational concepts of nursing empowerment. The sections of the questionnaire related to the motivational component of empowerment measured the motivating forces of self concept: self-esteem, self-efficacy, and authenticity. The data collected from these questions were used to answer the research questions:

1. Do nurses feel the role of the nurse is clearly defined to self and others?
2. What is the perception of nursing effectiveness?
3. Do nurses feel there is significance or meaning

related to one's role?

4. Do nurses differ in any of these categories as a function of educational preparation?

The sections of the questionnaire related to the relational component of empowerment collected data regarding environmental factors and were five in number. The data collected were used to answer the research questions:

1. Do nurses feel there is an adequate provision of information in the workplace?
2. Do nurses feel the resources available in the workplace are adequate?
3. Do nurses feel there are social support systems available in the work environment?
4. Is it perceived that autonomy is encouraged in role performance?
5. Do nurses differ in any of these categories as a function of educational preparation?

Limitations

For purposes of this study, the following were considered as limitations:

1. Generalizations to health care agencies of different size, philosophy, organizational structure, staffing patterns, or geographic location will be restricted.

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2. Recent stressful situations in an individual's work setting or in the nonwork setting may influence responses.
3. Previous work or life experiences may influence an individual's responses.

Significance and Implications of the Study

If it can be determined that there is a relationship between empowerment and factors associated with the work environment, hospital administrators, nursing leaders, and nurses themselves can begin to examine the environment to determine the degree to which empowerment is supported. Environments can be designed or strategies can be developed to enhance empowerment from the relational focus (Goddard, 1990; Becker, 1990).

If it can be determined that there is a relationship between empowerment and the individual's personal characteristics, then strategies that enhance the nurse's self-esteem, self-efficacy, and self-determination will lead to empowerment. In addition, if both motivational and relational factors influence empowerment, then it becomes apparent that to increase a sense of empowerment both the relational and motivational factors must be addressed (Becker, 1990).

Furthermore, if it can be determined that there is

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a relationship between either the motivational or relational components of empowerment and the educational preparation of the nurse, then nursing empowerment within a nursing unit or department may be influenced by the selection and retention of nurses based on educational preparation. In addition, if there is a relationship between empowerment and educational preparation, strategies to support nurses in furthering educational endeavors may become more important.

In a time when health care is rapidly changing, the need for empowered nurses becomes more important. Through empowerment, the individual nurse, the profession of nursing, the patient, other health care providers, and the organization can benefit. When an individual feels empowered, increased self-esteem, morale, and autonomy should result in increased job satisfaction. Role expectations will demand and support intelligent, skillful nurses in a challenging, changing career (Crissman & Wolf, 1989).

Increasing positive feelings of self-esteem, self-efficacy, and authenticity can lead to an improved image of the nurse. The profession of nursing can benefit from an improved image of nursing which may in turn lead to increased enrollments in nursing programs and decreased numbers of nurses leaving the profession.

The shortage of nurses has had a profound effect on health care; this shortage is expected to continue. Empowerment is one factor that can influence this trend (Ash, 1988).

Empowerment of nurses can lead to increased collaboration and collegiality among health care providers, potentially resulting in improved patient care and reduced health care costs. Organizations will benefit through empowerment of staff who provide quality patient care in an efficient, effective, and goal oriented manner (Iowa Tri-Council Summit Report, 1990).

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Chapter II

REVIEW OF THE LITERATURE

The purpose of the study was to examine the differences in the perceptions of nursing empowerment, including the motivational and relational components, between baccalaureate- and associate-prepared nurses. The literature review begins with a discussion of factors related to the socialization process of the female in health care, including characteristics of oppressed group behavior noted with dominant and subordinate groups. Maintenance of oppressed group behaviors in nursing resulting in powerlessness is described next. Motivational factors influencing empowerment, including the development of self-concept, self-esteem, self-efficacy, and authenticity, is included. A discussion of factors associated with the relational or environmental components of empowerment follows. The review also includes the influence of entry-level educational preparation on factors often associated with empowerment. An in-depth discussion of the study that was replicated by this research study, including both the motivational and relational components of empowerment, is presented. A summary concludes the review of the literature.

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Socialization Process of Women

Socialization is defined by Grisse and Spengler (1976) as a process by which one learns the expectations and obligations associated with a group role. Essentially, it is learning and living the culture of the group to which one belongs. Socialization, therefore, is affected by one's definition of self-concept (Grisse & Spengler, 1976).

Maslow's (1970) theory of human motivation addresses the basic needs inherent in all individuals, including physiological, safety and security, belongingness, esteem, and self-actualization that must be met according to a hierarchy of importance. Food, air, shelter, sleep, and oxygen make up the physiological needs. Safety and security needs including protection, stability, and freedom make up the second level of human motivational needs.

Once the physiological and safety needs are met, satisfying the needs for belongingness and self-esteem becomes important. Included in the belongingness category are the need for family, friends, and relationships. Self-esteem includes the desire for a favorable evaluation of oneself. From the moment of birth, an individual begins to get a feeling of self. Achievement, competency, adequacy, and respect from others are included in the determination of one's level

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of self-esteem. According to Maslow (1970), self-esteem needs and the desire for self-fulfillment affect one's contribution to a career. The final need of self-actualization is met when an individual reaches and functions at the highest self-determined level.

Logan (1985) and Greenleaf (1978) describe self-esteem as one's basic evaluation of self. The evaluation of self is dependent upon the response received by others to one's presence and behaviors. Self-respect and a sense of self-worth have an impact on one's self-esteem and are influenced by the socialization process.

Personal strength, competence, and control of relationships and the environment are also affected by one's perception of self. Those lacking in self-esteem often feel insecure, take fewer risks, distance themselves from others, and avoid change. Those with a secure sense of self are willing to take risks, establish relationships with others, and do not avoid change (Logan, 1985; Withers, 1978; Wynd, 1985).

Greenleaf (1978) describes a relationship between self-esteem, anxiety, and assertive behavior. A cyclic pattern develops with unassertive behavior, leading to loss of self-esteem, increased anxiety, and further unassertive behavior. High self-esteem results in the energy or enabling power to accomplish tasks, increase

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competence, and build self-confidence. Low self-esteem uses energy through confusion, fear, oppression, and anger (Greenleaf, 1978).

Traditionally, when women began to consider career choices, nursing, teaching, or secretarial positions were chosen. These careers reflect the socialization of women into nurturing, caring, serving, and supporting roles (Lovell, 1981). Historically, nursing was considered as a career because of religious reasons, as serving a purpose for society, or because other opportunities were not available to women (Cowden, 1978).

Many commonalities are noted in the development of female-dominated occupations such as nursing, teaching, and secretarial positions: women could provide a cheap and relatively plentiful supply of workers, the labor was basically nonmanual, and a fairly high degree of education was required. These roles were seen as an extension of the housewife and were expected to be temporary occupations. Women could have a career, but the role of wife and mother was their primary responsibility (Greenleaf, 1978).

Men and women define their jobs differently. Women look at their jobs from the day-to-day activities, while men see their jobs as a series of tasks and responsibilities related to goal achievement.

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Women indicate that a career should allow for personal growth, self-fulfillment, and should be satisfying. Men also include these aspects, but in addition, a career should be a progression of jobs that includes recognition and rewards. Men see a job as part of a career, while women tend to separate the two with the job being the here and now and a career as something to strive for (Hennig, 1977; Peters, 1982).

According to Wynd (1985) and Johnson (1976), women are socialized into roles of powerlessness and are taught to use ineffective power tactics that are less effective and less action producing. Indirectness, personalness, and helplessness are common female power styles, characterized by behaviors such as manipulating, avoiding direct confrontation, and placating. Men are socialized into roles of powerfulness, directness, concreteness, and competence. Characteristics associated with men are an ability to confront and resolve conflict, an ability to obtain and use resources, intelligence, logical thinking, and the courage to take risks (Wynd, 1985; Johnson, 1976).

A woman's self-esteem, ability to set goals, make career choices, and sense of power are a result of the female socialization process. With the feminist movement of the 1960s and 1970s, traditional female career choices and opportunities in the work force

began to change. An understanding of the historical perspective of women and nurses, including the changes initiated in the 1960s and 1970s, can help direct future changes in the socialization process (Crissman, 1989).

Oppressed Group Behaviors

Studies of group behaviors of the colonized Africans, the African Americans, and Jews have lead to the identification of behaviors associated with oppressed groups. Characteristics of oppressed group behaviors noted with dominant and subordinate groups often become evident when examining the behaviors of women in health care (Roberts, 1983).

In the situation where there are a dominant and a subordinate group, the dominant group attains its position because of its ability to identify and instill its norms and values as the desirable ones. In most cases of oppression, the dominant group has certain characteristics that are highly valued, while the subordinate group lacks these characteristics. Both groups believe that to have the valued characteristics of the dominant group leads to power and control (Roberts, 1983).

According to Miller and Mothner (1978), common characteristics associated with oppressed group

behavior include accepting the norms and values of the dominant group, imitating the dominant group, and then rejecting characteristics of one's own group. Feelings of low self-esteem and self-hatred result from the desire to change one's values and accepted norms. The subordinate group develops passive-aggressive behaviors against the dominant group, and horizontal violence within its own group. A fear of change, a loss of authenticity, and an evolution of marginal leaders develops (Miller & Mothner, 1978).

Low self-esteem, self-hatred, and a redefinition of self are evidenced by the loss of symbolism in nursing. White caps and uniforms portrayed nursing as a pure, nurturing, sacrificing, and caring profession. Moving away from this symbolism of wearing a uniform that identifies nurses as a group, and failure to replace this symbolism, shows evidence of low self-esteem and self-hatred (Crissman, 1989). Another example of low self-esteem cited by Crissman (1989) is that nurses, within their group, often refer to the caring, nurturing role of nursing as a key characteristic; yet outside the group nurses often place emphasis on the technological aspects of the role.

Roberts (1983) further describes evidence of low self-esteem and self-hatred in nursing's inability to

organize, direct, and govern itself. Low self-esteem is also noted by a lack of cohesion and participation in professional nursing organizations, implying a lack of pride in nursing.

Passive-aggressive behavior is seen when the subordinate group feels aggression toward the dominant group, but is unable to express it. The oppressed group may verbally complain about the dominant group, but a confrontation results in submission as a result of the low self-esteem and self-hatred. This passive-aggressive behavior results in continued feelings of frustration and failure, which lowers self-esteem and hinders effective negotiations between the groups (Roberts, 1983).

According to Fanon (1967), horizontal violence occurs as a result of the passive-aggressive behavior and an inability to revolt against the dominant group. Members of the oppressed group direct aggression against each other instead of the oppressor, resulting in internal conflict. This internal conflict is often interpreted as a characteristic inherent in oppressed or subordinated groups, further potentiating the belief that the subordinate group is unable to organize, function, and govern itself. The internal conflict further strengthens the division between the groups.

The evolution of marginal leaders occurs as some

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members of the subordinate group begin to assimilate characteristics of the dominant group. The marginals do not truly belong to either group. This attempt to be marginal leads to personality characteristics of self-hatred and low self-esteem in the oppressed group. Self-hatred and low self-esteem further contribute to internal conflict resulting in submissive-aggressive behavior (Roberts, 1983; Thompson, 1987).

Powerlessness in nursing has resulted through maintenance of these oppressed group behaviors. The primary mechanisms for maintaining oppression in nursing have been education, reward systems, and token appeasements (Roberts, 1983; Hedin, 1986).

Historically, educational systems have supported oppressed group behaviors and a dominant-subordinate relationship. Physicians have had input into nursing educational curriculum, thereby ensuring that nurses learn and believe the values of the dominant group. Physicians have also influenced the role of the nurse. Expanding the role of the nurse has served a variety of purposes for the physician. Delegating certain medical tasks to nurses has provided physicians the time and opportunity to continue their growth and expansion in medicine. As nurses have accepted medical tasks as part of their role, they have limited their opportunities to grow as a profession (Roberts, 1983).

Reward systems that are based on the values and beliefs of the dominant group tend to support oppression. Nurses are further aligned in a subordinate position when they are recognized and rewarded for the medical contribution to health care rather than the nursing contribution to health care (Crissman, 1989).

Another mechanism that supports oppressed group behavior occurs when there is a threat of revolt or change and the dominant group offers a token appeasement to the subordinate group. Token appeasements are often seen through committee appointments, position changes, delegation of tasks, or salary increases. As the subordinate group accepts this appeasement, the momentum for change subsides (Roberts, 1983).

The maintenance of oppressed group behavior results in continued feelings of powerlessness. Nursing empowerment can occur with the identification of these behaviors and the development and implementation of strategies to support nursing empowerment.

Motivational and Relational Factors of Empowerment

Conger and Kanungo (1988) present a framework for studying empowerment that includes both motivational

and relational components. The relevance to management theory can be applied in the practical nursing arena.

In the first stage of the empowerment process, conditions leading to a psychological state of powerlessness are identified. Organizational factors such as the type of management style, the degree and amount of supervision, reward systems, mechanisms for recognition of excellence in nursing practice, employee-management relations, and the nature of the job are aspects to examine as potential contributors to powerlessness (Conger & Kanungo, 1988).

Managerial use of techniques and strategies to remove external conditions causing powerlessness is the focus of stage two. Participative management, shared governance, goal setting, feedback systems, role modeling, contingent/competence-based reward systems, and job enrichment are examples of management strategies aimed at reducing powerlessness (Conger & Kanungo, 1988; Crissman & Wolf, 1989, Becker, 1989).

Empowerment results when nurses identify strategies to unify within an organization. Strategies that support nursing empowerment include nurses' capitalization of centrality, identification of conditions which contribute to the uniqueness of nursing, and demonstration of nursing's assets (Stuart, 1986).

Defining the role of the nurse as the coordinator of patient care leads to a decrease in duplication of effort, increased efficiency of patient care, and feelings of empowerment. Developing collegial relationships among other health care providers contributes to the success and degree of empowerment of the nurse in the role of patient care coordinator (Strasen, 1989).

Maximizing nursing participation in decision making at all levels results in a balance of power within the organization. The empowerment process should include the nurse's ability to make decisions that affect patient outcomes, relate to the work environment, and influence future strategic and financial planning decisions (Harrison & Roth, 1987; Willey, 1987).

During stage three, the manager begins to provide individuals with self-efficacy information. Bandura (1986) describes self-efficacy as the individual's belief that his or her efforts will result in a desired level of performance and that this performance will produce a desired outcome. Through the empowerment process an individual's self-efficacy expectations will be enhanced. Use of reward and recognition strategies are important in the development and perpetuation of these positive behaviors. The individual needs to feel

that he or she makes a difference in the organization. Also during stage three, the manager strives to remove the conditions leading to powerlessness noted during stage one (Conger & Kanungo, 1989).

As a result of the strategies utilized in stage three, the subordinates begin to feel empowered in stage four. The manager continues to use successful strategies to strengthen the empowerment experience. Managers must develop and maintain an environment that nurtures, supports, and assists individuals in the empowerment process. The belief that empowerment is not something that is given to an individual, but instead is something that must be fostered from within, allows the empowerment process to grow and survive (Conger & Kanungo, 1989; Crissman & Wolf, 1989, Becker, 1989).

In stage five, the effects of empowerment become evident and result in individual and organizational behavioral changes. A corporate culture reflecting the organization's philosophy and mission will provide strength to the empowerment process (Goddard, 1990; Conger & Kanungo, 1989).

In a descriptive study by Gorman and Clark (1986), 170 nurses were interviewed to identify nursing empowering strategies. Teaching analytical nursing, promoting team-building and networking, improving

collegial relations, peer consultation and support, and increasing utilization of resources and information were the primary strategies reported.

Several researchers have examined organizations to identify strategies that influence success. In studying various workplaces, Kanter (1983) noted that allowing employees to participate in decision making facilitates organizational success. In addition, supporting and rewarding innovative employees also leads to organizational success and fosters the empowerment process.

In an exploratory study by Chandler (1988), the relationship among the environment, nursing empowerment and powerlessness was examined. Two hundred sixty-eight nurses from two hospitals of similar size, purpose, and location in northeast Utah participated in the study. The participants completed an Effective Work Conditions Questionnaire and a demographic data form. The subscales rated on the questionnaire using a five-point scale included opportunities, supplies, job activities, information, and support. Results of the statistical analysis indicated a significant difference in nurses' perceptions of the importance of support, information, and opportunity as important factors affecting work conditions. Supplies and job activities were not statistically significant factors reported as

important in affecting work conditions. Organizational leaders were described as to their positive or negative influence on empowerment. Chandler (1988) found that leaders who shared power, rewarded initiative and encouraged growth of employees developed and maintained effective staff members. Powerless leaders who were unable to share power and who were unsuccessful in recognizing and rewarding initiative and growth limited the effectiveness of employees.

Factors which influence the development of an individual's self-concept, self esteem, self efficacy, and self consistency or authenticity serve as a source of motivation for the human development process. These motivating forces become factors to consider in the motivational aspect of empowerment (Gecas, 1982; Gecas, 1988).

Gecas (1982) describes the motivational force of self-esteem as the desire to maintain and enhance a positive image of oneself. Individuals with high self-esteem strive for self-enhancement while individuals with low self-esteem are motivated by self-maintenance. Self efficacy is the second motivational force of the self concept. Self efficacy relates to one's perception of oneself as a change agent, the ability to achieve goals, and the ability to take control of a situation. Self-efficacy has been described by a

number of authors as a factor related to one's level of competence and the degree of autonomy.

Bandura (1977) described low self-efficacy as a result of feelings of frustration requiring that one either become more competent or that environmental job expectations be modified. High self-efficacy results from a sense that one can successfully perform a specific behavior required to produce a desired outcome. A sense of successful accomplishment and a feeling of competence in an environment that supports these behaviors further support self-efficacy and one's ability to cope.

The third motivational force is authenticity or self consistency. Authenticity is often described as a sense of realness or significance to others or to situations. Authenticity assigns meaningfulness to oneself and one's beliefs. Significance to others, including recognition, support, affirmation, and trust are essential components which influence authenticity and one's consistent response pattern to others or situations (Gecas, 1982; Turner, 1976).

Motivational forces of self-concept were studied by Joseph (1985) in relation to sex-role stereotype. The relationship between self-concept and nurses' attitudes regarding decision making was studied in a group of 85 nurses randomly selected from two large

metropolitan hospitals. The Joseph Decision-Making Tool was administered to staff nurses working all three shifts, ranging in age from 20 to 60 years, and with different levels of nursing education and experience. Joseph (1985) found that the willingness of nurses to make practice decisions was not significantly related to self-concept scores. Individuals with masculine sex-types and who graduated from diploma programs believed that nurses should assume responsibility for decision making. Both of these variables were significant at the $p < .01$ level. He also found that the amount of experience a nurse had was negatively related ($p < .01$) to a willingness to make decisions. However, factors in the workplace were not examined in this study and may have influenced the findings.

Goldstein (1980) studied characteristics associated with self-actualization of baccalaureate- and associate-prepared graduating seniors. Two hundred and four baccalaureate and 59 associate degree students, selected by a convenience sample from 20 Illinois nursing programs, were included in the study. Statistically significant differences ($p < .001$) were found in leadership characteristics between the baccalaureate- and the associate-prepared nurse using the Personal Orientation Inventory questionnaire developed by Shostrom (1966). The baccalaureate

student scored higher than the associate nurse on all scales measuring leadership factors associated with self-actualization.

Murray and Morris (1982) studied graduating seniors from each of three nursing programs to determine whether a difference in autonomy existed. The Personal Orientation Inventory developed by Shostrom (1966) was administered to a convenience sample of 80 students from an associate program, 85 students from a diploma program, and 59 students from a baccalaureate program. The measurement of autonomy included differences in time competence, inner or outer support, self-perceptions, and interpersonal sensitivities. There was no significant difference noted in time competence, however baccalaureate nursing student scores were higher than those of associate nursing students in all other areas ($p < .001$) when comparing professional autonomy.

Nursing educational preparation and selected characteristics associated with job satisfaction were studied by Stewart-Dedmon (1988). A total of 216 subjects from baccalaureate, diploma, and associate nursing programs were included in this comparative survey. Baccalaureate and diploma nurses were found to be significantly less satisfied with the overall nursing position, the opportunity for prestige, and

self-fulfillment than associate degree nurses. Diploma nurses were significantly less satisfied with the opportunity to be promoted based on performance than baccalaureate-prepared nurses.

Brief (1979) studied factors associated with educational preparation and job-role stress utilizing a randomly selected sample of general duty nurses employed full-time. One hundred-fifty-seven usable questionnaire responses were received from a stratified sample of nurses with one-third of the subjects from baccalaureate, one-third from diploma, and one-third from associate programs. A statistically significant difference of $p < .05$ in role conflict and of $p < .01$ in role ambiguity was noted based on educational preparation. The baccalaureate-prepared nurse reported significantly higher role stress and higher role ambiguity than the diploma- or associate-prepared nurse.

Becker's Study

In a longitudinal study by Becker (1990), components of empowerment were examined. These components include the superstructure; the infrastructure; the professional practice environment; self-concept; motivational forces of self-esteem, self-efficacy, and authenticity; the means to empowerment;

and the goal of empowerment in role performance. Each of these components was examined through the use of a three-part tool developed by the researcher. Becker administered the empowerment tool to 30 new nursing employees in a large metropolitan hospital in the Midwest. All new nursing employees were offered the opportunity to be included in the study until the sample size of 30 was reached. These nurses attended a program about empowerment after completion of orientation and were retested after one year of employment to show effects of the empowerment program.

According to Becker (1990), the superstructure consists of the defined roles in health care, the governmental regulations, religious beliefs about the care of the sick, and licensing regulations. Essentially, the superstructure is the influence of the socioeconomic system on the political and legal structure of the health care system.

The infrastructure represents the changing work systems. This includes the reward and recognition systems, salary and benefits, type of nursing care delivery system, job design, reporting relationships and committee structure. According to Becker (1989), the superstructure and the infrastructure together serve to stimulate or inhibit, to enhance or frustrate, and to advance or stifle the growth of the nurse

(Becker, 1989).

Becker (1989) includes the self as a measurement component of empowerment, emphasizing self-concept and the motivating forces of self-esteem, self-efficacy, and authenticity. Interactions and experiences in the work environment will influence the development of the nurse and his/her self-concept (Becker, 1989).

In Becker's (1980) research, the measurement of change in empowerment levels of the nurse related to the levels of the motivating forces of self-concept were examined. In addition, the relationship between empowerment and certain environmental factors in the workplace were included (Becker, 1989).

In this proposed study, Becker's (1989) research tool was be used to gather additional data examining the superstructure and the infrastructure as applied in a variety of practice environments in an organizational setting with similar characteristics. Becker's (1989) study examines factors related to empowerment from a longitudinal study. In contrast, this study will attempt to determine whether factors related to empowerment can be identified from a cross-sectional examination. Through the analysis of data, management strategies or factors that create a productive work environment to support personal and professional development can be identified (Becker, 1989).

Summary

The review of the literature began with a discussion of the socialization process of the female in health care, oppressed group behaviors resulting in powerlessness, and motivational and relational factors influencing nursing empowerment. Research studying the differences in responses based on educational preparation was included. Differences were noted in the areas of self-actualization, job-role stress, satisfaction with the overall nursing position, the opportunity for prestige, self-fulfillment, autonomy, and leadership characteristics.

Research including both the motivational and relational components of nursing empowerment, including correlating these variables to educational preparation, is limited. Entry-level educational preparation could be an important factor associated with the nurse's perception of empowerment, as well as a factor influencing the ability to implement strategies to promote nursing empowerment.

Chapter III

METHODOLOGY

The purpose of this study was to examine the differences in motivational and relational components of empowerment between staff nurses prepared at the baccalaureate and associate degree levels. In this chapter the subjects, investigator, instruments, research design, scoring of the instruments, procedure for data collection, and methods of data analysis are described.

Subjects

The target population for this descriptive study was registered nurses practicing in a variety of clinical specialty areas. The registered nurses included in this study were employed at least 20 hours a week in a medium-sized hospital located in the Midwest. All registered nurses from the specialties selected were invited to participate in the study.

Investigator

The primary researcher was a registered nurse practicing in the position of Director of Nursing Practice/Quality Assurance in another health care organization. The researcher was not in a direct

supervisory position of any of the subjects participating in the study.

Research Instrument

For purposes of this study, a three-part tool developed by Becker (Appendix A) was used. Becker's tool consisted of the RN Growth and Development Survey (GDS), the Professional Practice Survey (PPS), and the Survey of Professional Practice Environment (PPE). This survey tool was designed to measure the nurses' perceptions of the motivational and relational components of nursing empowerment (Becker, 1989).

The initial portion of this self-report instrument consists of 12 questions related to demographic data, including the following: age, marital status, educational preparation, nursing specialty, years of experience, and any previous knowledge related to empowerment. Subjects responded by selecting the appropriate choice from a given set or by writing in a short response (Becker, 1989).

The GDS portion consists of 24 questions intended to measure individual perceptions about nursing empowerment. Responses range from almost always to almost never on a five-point Likert scale (Becker, 1989).

The PPS portion consisted of paired phrases

requiring the subjects to respond using a Likert scale ranging from one to five indicating the response that best describes their normal behavior or tendency in a clinical situation. This portion of the survey tool was intended to measure the degree of freedom perceived by the respondents in the professional work setting. Levels of self-esteem, self-efficacy, and authenticity as the motivational component of empowerment were also measured in this portion of the survey (Becker, 1989).

The PPE portion consisted of 43 questions requiring the subjects to respond using a Likert scale ranging from one to five indicating the frequency with which characteristics of empowerment are noted in the work setting. This portion of the survey specifically addressed the respondent's perception of the work environment or the relational component of empowerment (Becker, 1989).

A change in questionnaire format was used for each portion of the instrument to help prevent response set. One question was changed from the original tool, since this question referred to a specific organizational policy by name, it that was not relevant in this setting. The questionnaire was completed in approximately 20 minutes (Becker, 1989).

Content validity of the instrument was tested by Becker through review, critique, and agreement by six

experts in the field of nursing empowerment. These experts were Master's-prepared nurses employed in nursing management-administrative positions in a large metropolitan hospital. All three parts of the instrument were tested for reliability by Becker. The first two parts of the survey tool were tested for reliability by Becker (1990) using a convenience sample of 60 new nursing employees in a large tertiary care hospital in the Midwest. The survey tool was administered to the nurses at the beginning of employment. The survey tool was then readministered approximately one month later. The third portion of the survey tool has been tested for reliability with the last 30 nurses in the sample. The convenience sample of nurses used for testing reliability represented nurses from all subspecialties that were included for data collection in the actual study. The tool was determined by Becker to be reliable at $\alpha = 0.79$ and 0.83 respectively, using Crombach's Alpha (Becker, 1989).

Research Design

An ex post facto research design was used in this descriptive study. Wilson (1985) defines ex post facto as follows:

A study design that literally studies something

after the fact instead of manipulating an independent variable (p. 566).

Descriptive designs are nonexperimental in nature and are used when the purpose is to generate new facts.

Abdellah and Levine (1987) state:

Description implies natural observation of the characteristics of the research subjects without deliberate manipulation of the variables or control over the research setting (p. 200).

Entry level educational preparation was the independent variable that was studied. This study related this independent variable to the dependent variables of motivational and relational components of nursing empowerment.

Procedure

The questionnaire was distributed through employee mailboxes to all RNs employed greater than 20 hours per week on all nursing units. A letter describing the study, which included the consent to participate in the study (Appendix B) and an addressed envelope for return of the questionnaire, was included with the first distribution. A large collection box was located in the nursing secretarial office for return of the questionnaires in the provided envelopes. The returned consent forms were compared with the initial

distribution list to determine individuals who had not responded. A second distribution of the questionnaire followed in two weeks to solicit responses from those not returning the questionnaire from the first mailing (Appendix C). All questionnaires were coded to prevent duplication of responses and to allow for retrieval of data had an individual decided to withdraw from the study after returning the survey. Data from the returned questionnaire were not linked to the respondent's name. Data collection concluded two weeks after the second distribution.

Ethical Considerations

The thesis proposal was submitted for approval to the Drake University Human Subjects Research Review Subcommittee of the Faculty Senate before the onset of the research. Permission for data collection was obtained from the involved hospital's Vice President, Director of Nursing, and the Institutional Review Committee. Participation in the study was voluntary and subjects could withdraw at any time. A consent form for participation in the study was included with the survey tool (Appendix B). The consent form informed participants that they need not sign their names to the questionnaires and that all information would be kept strictly private and confidential. The

cover letter contained the code number of the questionnaire in the event the participant decided to withdraw from the study after returning the completed questionnaire.

CHAPTER IV

ANALYSIS

In this section, characteristics of the survey sample will be described. Group demographic data will be presented followed by a breakdown based on educational preparation. The statistical analysis related to the research questions and the hypotheses will follow. This section will conclude with a discussion of incidental findings.

Description of Sample Subjects

From a convenience sample of 100, the total response was 47, or a 47% response rate. A total of 36 surveys could be used for this study. Eleven of the respondents were excluded from the database since they did not meet the requirement of ADN or BSN educational preparation. Ten of those excluded were Diploma-prepared, and one respondent indicated both ADN and Diploma educational preparation. All 36 respondents completed the entire three-part survey tool, although three respondents left one or two questions blank.

Two weeks following the initial distribution, 34 survey responses (34%) were received. Two weeks after

the second distribution 13 (13%) additional survey responses were returned.

All statistical analysis was based on the 36% usable response rate. Figures 1-8 describe the demographic data, including the age distribution; years of experience as an RN/GN; entry level of educational preparation; marital status; specialty area of nursing; distribution of length of time as an employee within the sample setting; and previous attendance at educational programs focusing on empowerment, women's studies, or oppressed group behavior (see Figures 1-8).

Similarities between ADN and BSN group demographic data were noted in the areas of age, marital status, specialty area of nursing practice, length of time in specialty area, and time employed within the organization. Differences were noted in ADN and BSN responses related to attendance at programs on empowerment, oppressed group behavior, and women's issues.

Sixty-seven percent of the ADN respondents were ages 21 to 40, and 33% were older than age 41. Sixty percent of the BSN respondents were ages 21 to 40 and 44 percent were older than 41 years. Seventy-one

Figure 1
AGE DISTRIBUTION

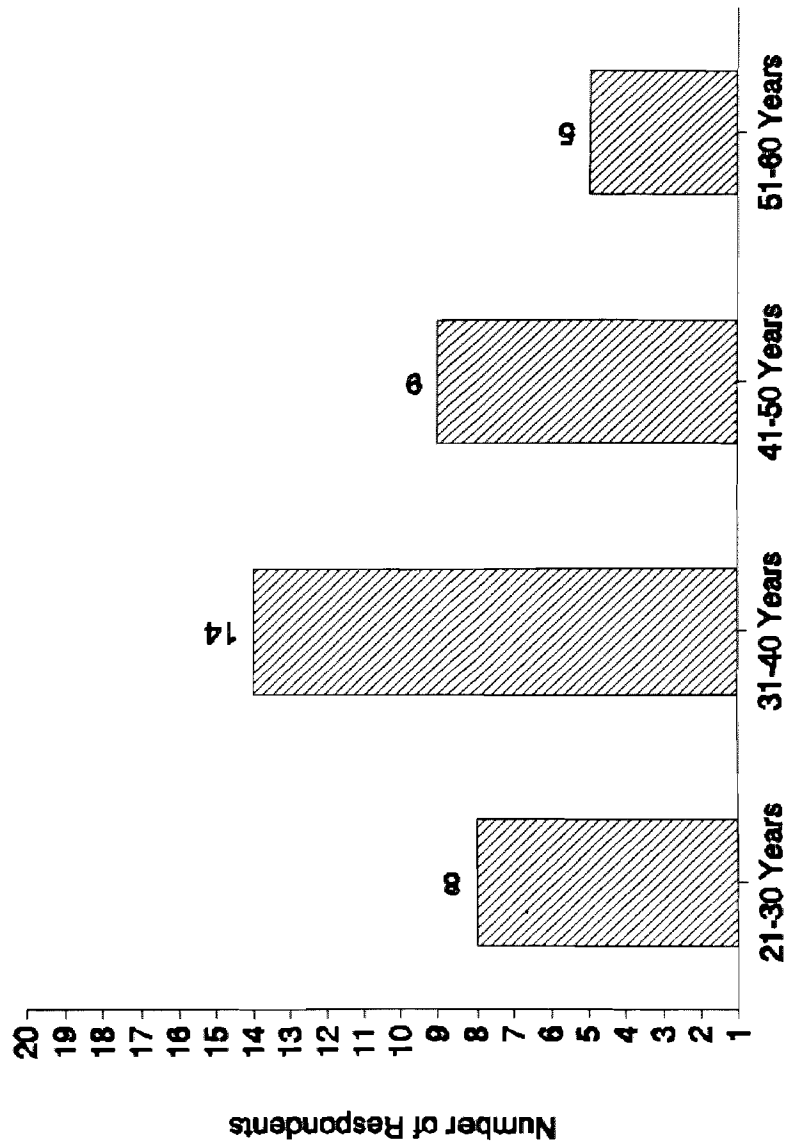


Figure 2

YEARS EXPERIENCE AS RN/GN

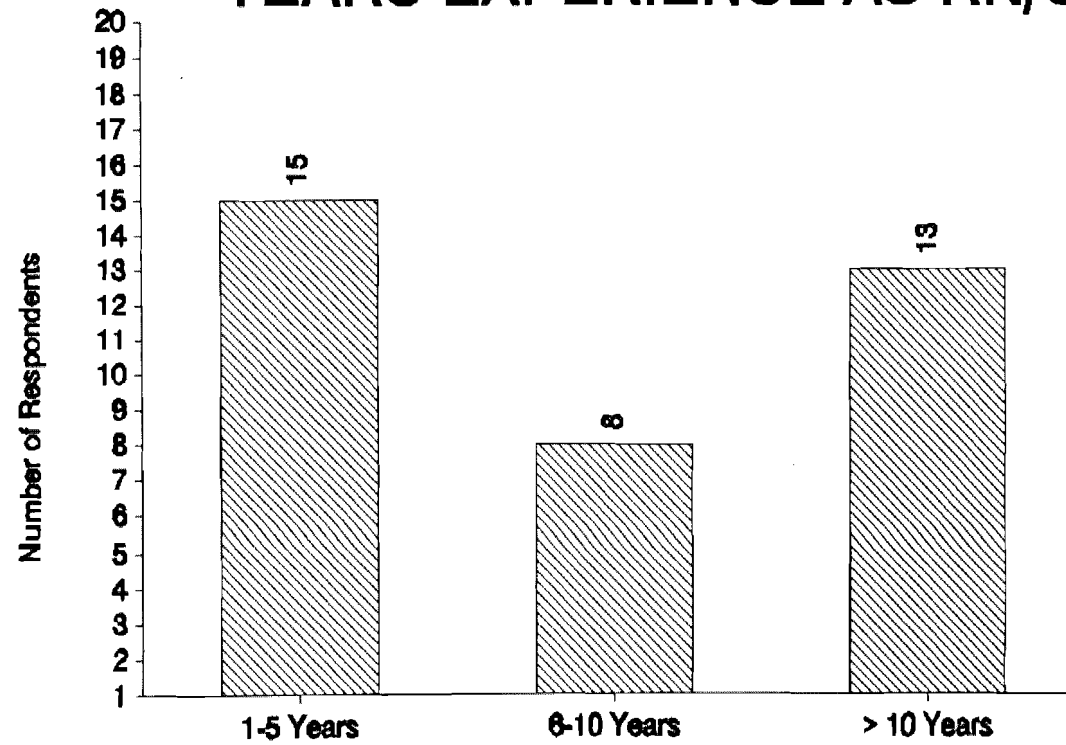
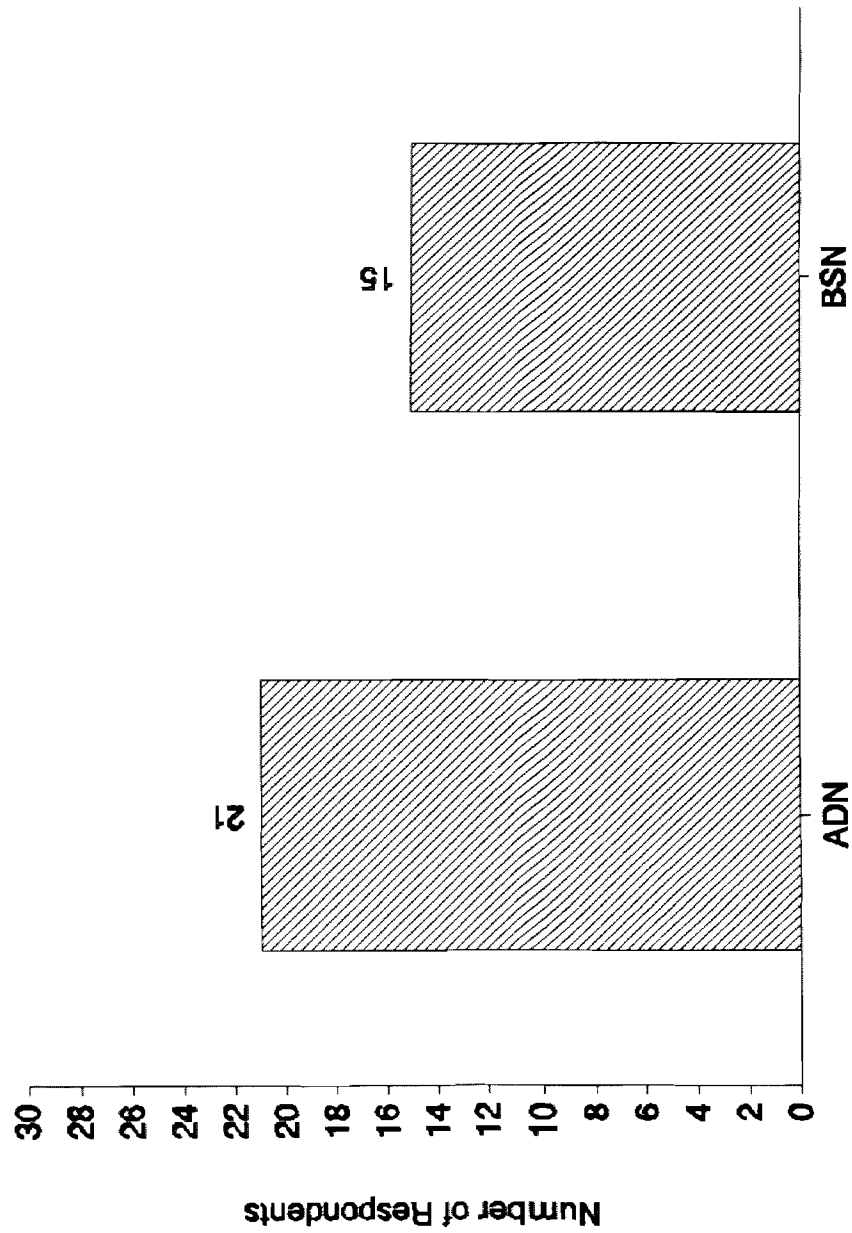
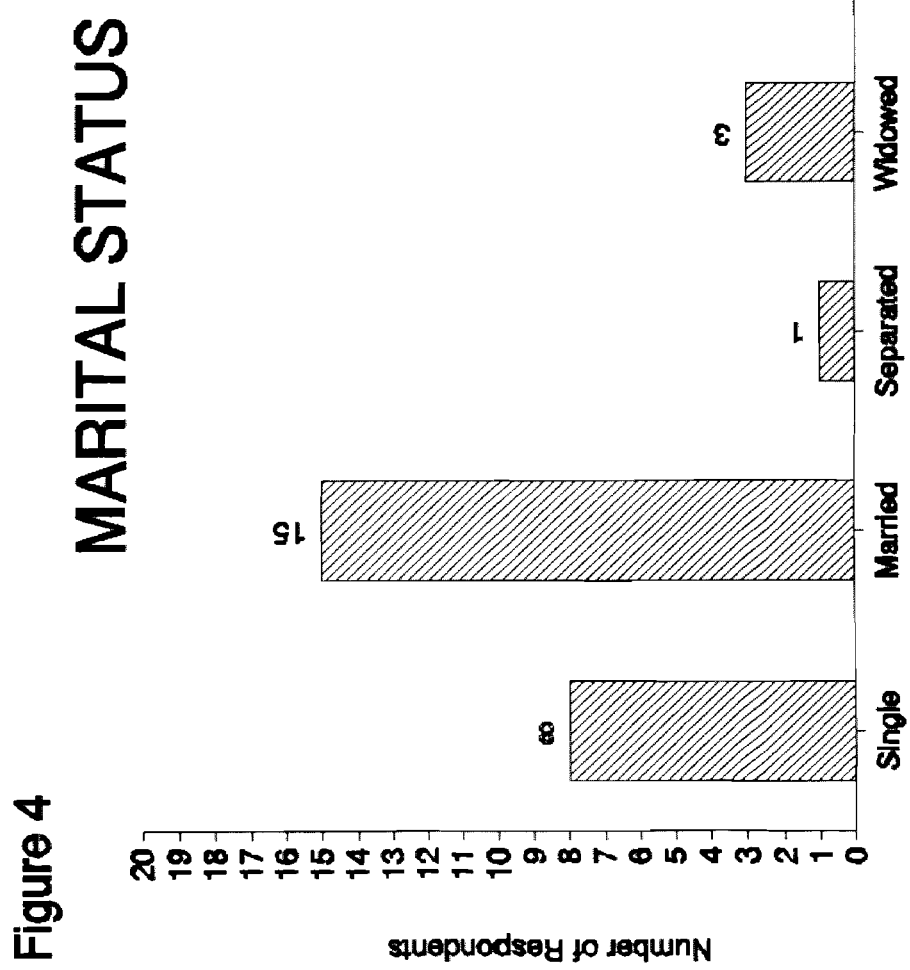
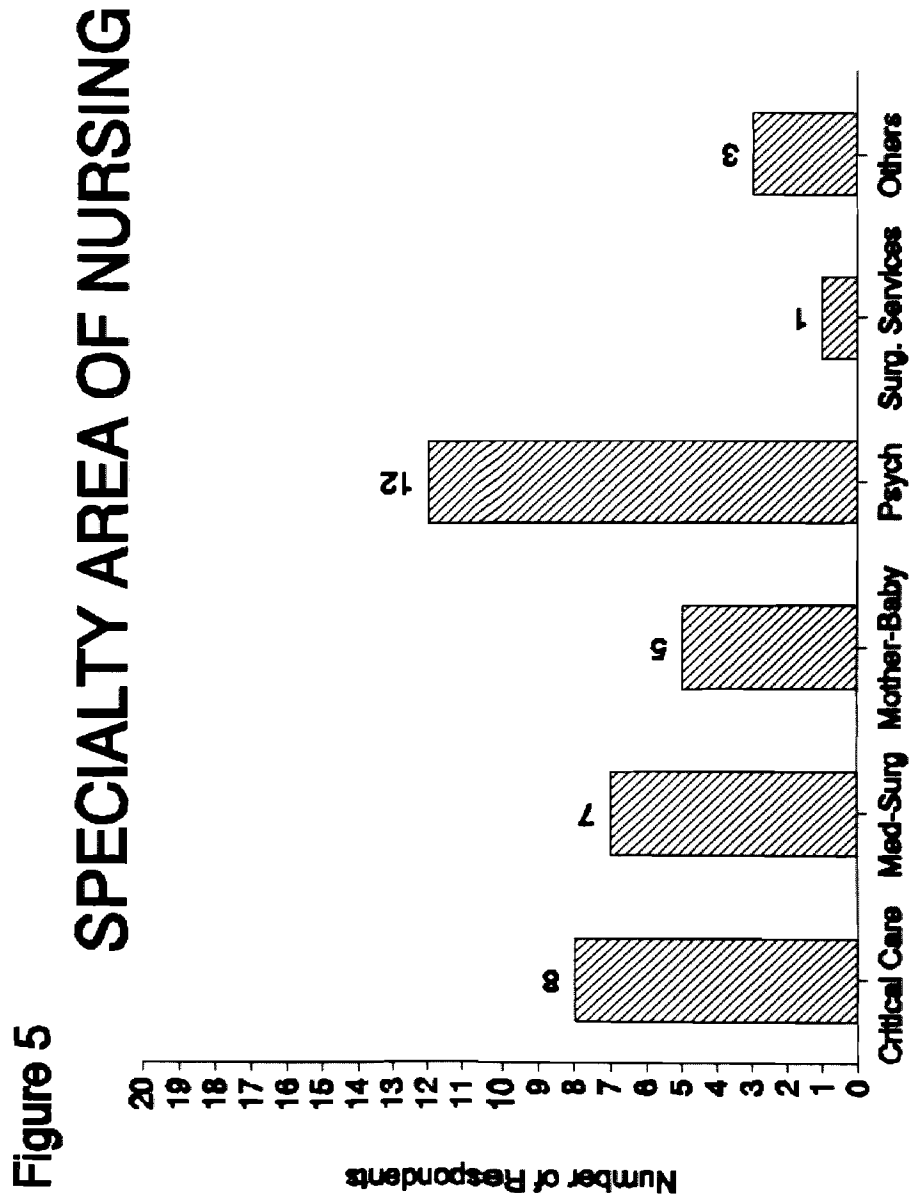
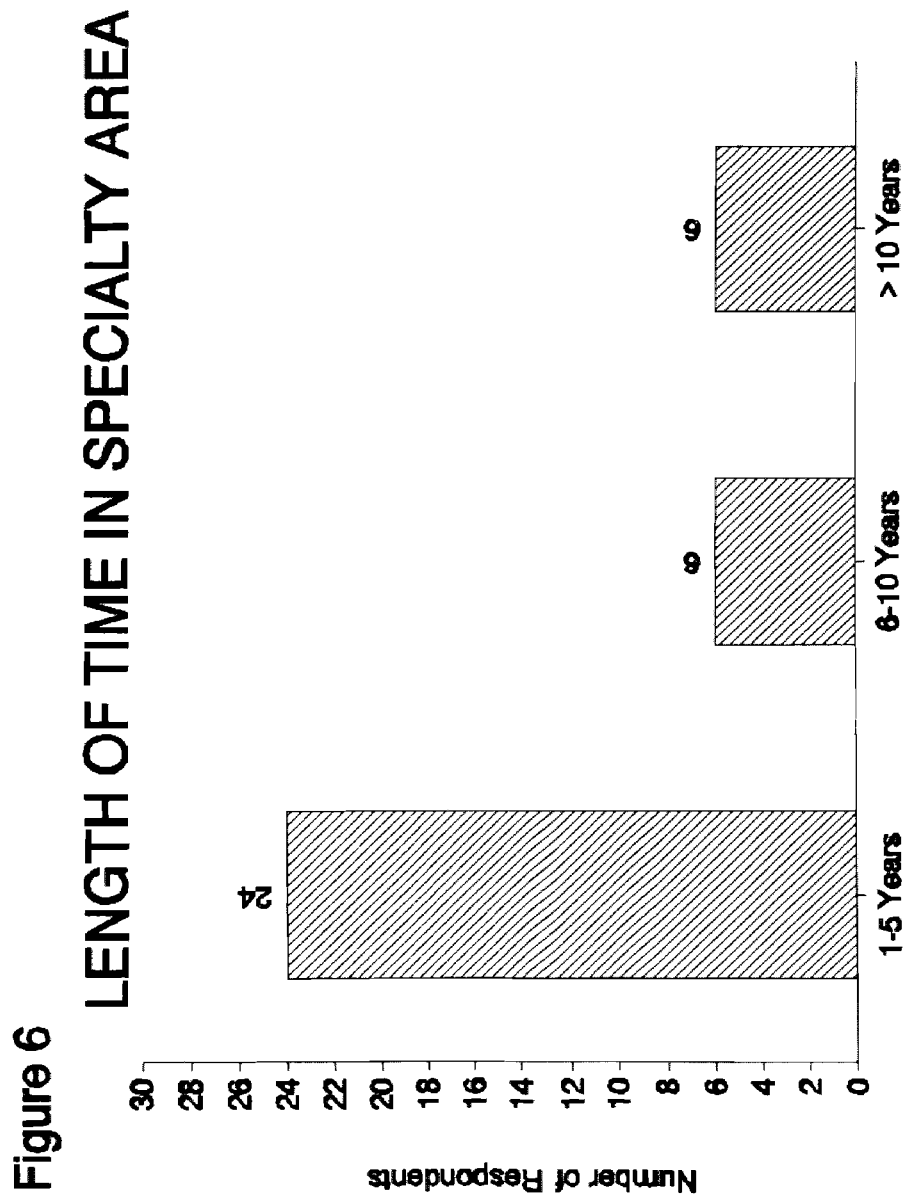


Figure 3
ENTRY LEVEL OF EDUCATIONAL PREPARATION









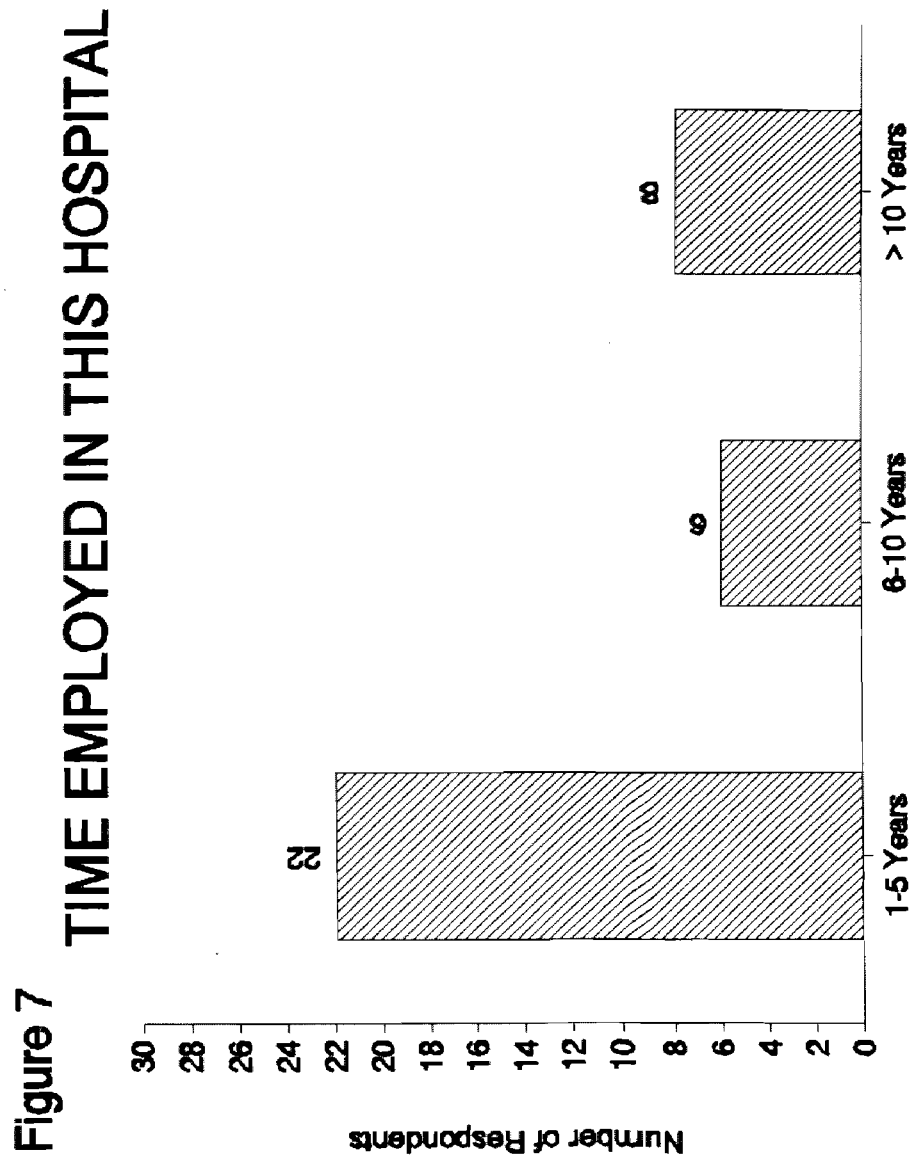
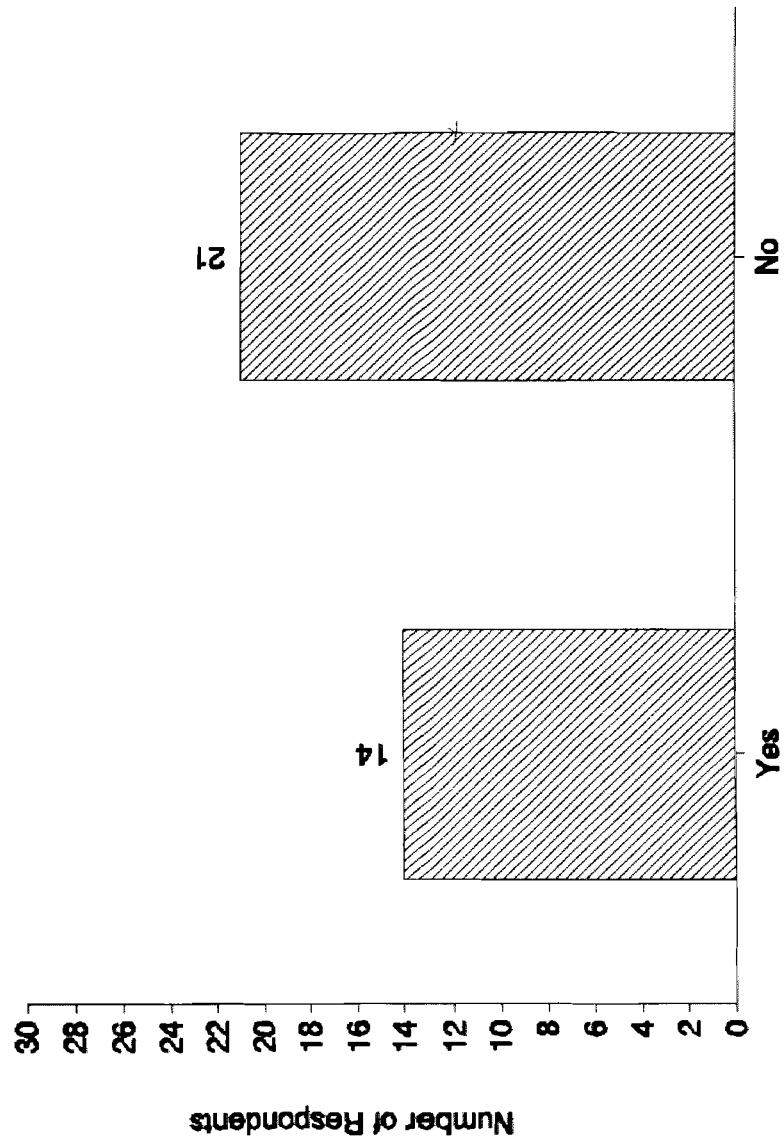


Figure 8 **PREVIOUS EDUCATIONAL ATTENDANCE**



percent of the ADN respondents had 1 to 10 years' experience as an RN/GN and 29% percent had more than 10 years' experience. Sixty percent of the BSN respondents had 1 to 10 years' experience and 40% had more than 10 years' experience.

The most common responses for marital status included married, single, and divorced. Thirty-eight percent of the ADN respondents were married, and 40% of the BSN respondents were married. Single marital status was higher for BSNs (30%) than ADNs (14%). Twenty-eight percent of the ADNs were divorced, and 20% of the BSNs were divorced.

The responses for specialty area of nursing included critical care, medical-surgical, mother-baby, psychiatric, surgical services, and outpatient/ED (other category). A higher percentage of BSNs were employed in the psychiatric setting (47%) as compared to ADNs (24%). Twenty-seven percent of the ADN and 19% of the BSNs worked in critical care. Twenty-four percent of the ADNs and 20% of the BSNs worked in medical-surgical nursing. Nineteen percent of the ADN respondents were employed in the mother-baby specialty, with 7% of the BSN respondents. Nine percent of the

ADNs were employed in an outpatient or ED setting, compared to 7% of the BSNs.

Seventy-one percent of the ADN respondents had 1 to 10 years' of experience in their specialty area versus 66% of the BSNs. Twenty-nine percent of the ADNs had more than 10 years' experience in their specialty area as compared to 33% of the BSNs. Seventy-six percent of the ADNs and 80% of the BSNs had been employed in this hospital for less than 10 years.

A higher number of BSN respondents had attended an educational program on empowerment, women's studies or oppressed group behavior (47%) than ADN respondents (29%). However, descriptions of the program, the length, and the year attended varied greatly among all respondents.

Statistical Analysis

The findings failed to determine a significant difference in perceived levels of nursing empowerment based on educational preparation. Each of the hypotheses will be discussed separately, as well as the findings related to the associated research questions.

Hypothesis 1

Hypothesis 1 stated "There will be a statistically significant difference in reported perceptions of the motivational or self-concept component of nursing empowerment of the baccalaureate- and the associate-prepared nurse employed in an acute care setting." The following research questions were associated with hypothesis 1:

1. Do nurses feel the role of the nurse is clearly defined to self and others?
2. What is the perception of nursing effectiveness?
3. Do nurses feel there is significance or meaning related to one's role?
4. Do nurses differ in any of these categories as a function of educational preparation?

Independent t tests were conducted to determine whether there was a significant difference in the perceived levels of the motivational component of nursing empowerment based on educational preparation. Questions from the RN Growth and Development Survey related to the motivational forces of self-esteem (i.e., Who am I? and Who do you perceive me to be?), self-efficacy (i.e. How do I measure up? and What is

your perception of my effectiveness within the defined power structure of my life?), and authenticity (i.e., Am I significant? and Do you believe in and trust me?). A breakdown of survey tool questions related to self esteem, self-efficacy and authenticity is presented in Appendix D.

Table 1

SELF-ESTEEM RELATED TO EDUCATIONAL PREPARATION

Educ Prep	<u>n</u>	Mean	<u>t</u> value	Probability
ADN	21	3.43		
BSN	15	3.40	0.27	0.78

Table 2

SELF-EFFICACY RELATED TO EDUCATIONAL PREPARATION

Educ Prep	<u>n</u>	Mean	<u>t</u> value	Probability
ADN	21	3.49		
BSN	15	3.57	-0.50	0.61

Table 3

AUTHENTICITY RELATED TO EDUCATIONAL PREPARATION

Educ Prep	<u>n</u>	Mean	<u>t</u> value	Probability
ADN	21	3.40		
BSN	15	3.47	-0.48	0.63

There was no statistically significant difference noted in responses to this group of questions based on educational preparation. A composite score of the motivational components including self esteem, self efficacy and authenticity also indicates no significant difference based on educational preparation (see Appendix E). Therefore, the first null hypothesis, which stated "There will be no significant difference in the perceived levels of the motivational component of nursing empowerment and educational preparation," was not rejected.

Hypothesis 2

Hypothesis 2 stated "There will be a statistically significant difference in reported perceptions of the relational or environmental component of nursing empowerment of the baccalaureate- and the associate-prepared nurse employed in an acute care setting." The following research questions were associated with this hypothesis:

1. Do nurses feel there is an adequate provision of information in the workplace?
2. Do nurses feel the resources available in the

workplace are adequate?

3. Do nurses feel there are social support systems available in the work environment?
4. Do nurses perceive that autonomy is encouraged in role performance?
5. Do nurses differ in any of these categories as a function of educational preparation?

Independent t tests were conducted to determine whether there was a significant difference between the relational component of empowerment and educational preparation (see Tables 4-11). Questions from the Professional Practice Survey and the Survey of Professional Practice Environment focus on the relational forces of empowerment. Questions in the Professional Practice Survey focus on the nurse's perception of use of information, use of resources in the environment, use of support of others, and the demonstration of autonomy in role performance. A breakdown of the survey tool questions related to the usage of the relational components of empowerment are presented in Appendix F.

Table 4

INFORMATION USAGE BASED ON EDUCATIONAL PREPARATION

Educ Prep	<u>n</u>	Mean	<u>t</u> value	Probability
ADN	21	3.71		
BSN	15	4.11	-2.10	0.04*

Table 5

RESOURCE USAGE BASED ON EDUCATIONAL PREPARATION

Educ Prep	<u>n</u>	Mean	<u>t</u> value	Probability
ADN	21	4.21		
BSN	15	4.08	0.81	0.42

Table 6

SUPPORT SYSTEM USAGE BASED ON EDUCATIONAL PREPARATION

Educ Prep	<u>n</u>	Mean	<u>t</u> value	Probability
ADN	21	4.21		
BSN	15	4.30	-0.74	0.46

Table 7

DEMO OF AUTONOMY BASED ON EDUCATIONAL PREPARATION

Educ Prep	<u>n</u>	Mean	<u>t</u> value	Probability
ADN	21	3.77		
BSN	15	4.05	-1.42	0.16

Questions in the Survey of Professional Practice

Environment focus on the nurse's perception of the level of information provided, the level of resources provided, the encouragement of social support, and the encouragement of autonomy in role performance.

Table 8

PERCEPTIONS OF INFORMATION PROVIDED
BASED ON EDUCATIONAL PREPARATION

Educ Prep	<u>n</u>	Mean	<u>t</u> value	Probability
ADN	21	3.50		
BSN	15	3.34	0.79	0.43

Table 9

PERCEPTIONS OF RESOURCES PROVIDED
BASED ON EDUCATIONAL PREPARATION

Educ Prep	<u>n</u>	Mean	<u>t</u> value	Probability
ADN	21	3.06		
BSN	15	3.00	0.26	0.79

Table 10

PERCEPTIONS OF SUPPORT PROVIDED
BASED ON EDUCATIONAL PREPARATION

Educ Prep	<u>n</u>	Mean	<u>t</u> value	Probability
ADN	21	3.15		
BSN	15	3.21	-0.26	0.79

Table 11

PERCEPTIONS OF AUTONOMY ENCOURAGEMENT
BASED ON EDUCATIONAL PREPARATION

Educ Prep	<u>n</u>	Mean	<u>t</u> value	Probability
ADN	21	3.22		
BSN	15	3.23	-0.04	0.96

There was no statistically significant difference ($p < .05$) noted in responses to this group of questions based on educational preparation. A composite score of the relational components of empowerment focusing on provision and use of information, resources, support, and autonomy indicates no significant difference (Appendix G). Therefore, the second null hypothesis, which stated "There will be no significant difference in the perceived levels of the relational component of nursing empowerment and educational preparation," was not rejected.

Incidental Findings

Other factors may have an impact on the perceptions of nursing empowerment. In addition to examining the perceptions of the relational and motivational components of empowerment related to educational preparation, differences based on age and the number of years of experience were also examined. Interval data were converted to ordinal data to analyze age differences with the two groups defined as age 30 or below and over age 30. The age groups of 40 or below and over age 40 were also used. An independent t test

was conducted to determine whether there was a relationship between age and the motivational or relational component of empowerment. There was no statistically significant difference noted with either of the age groups (see Appendix H).

Table 12

SELF-ESTEEM RELATED TO AGE

AGE	<u>n</u>	Mean	<u>t</u> Value	Probability
< 30 Years	8	3.38		
> 30 Years	28	3.42	-0.27	0.78
< 40 Years	22	3.44		
> 40 Years	14	3.38	-0.50	0.61

Table 13

SELF-EFFICACY RELATED TO AGE

AGE	<u>n</u>	Mean	<u>t</u> value	Probability
< 30 Years	8	3.40		
> 30 Years	28	3.56	-0.82	0.41
< 40 Years	22	3.51		
> 40 years	14	3.54	-0.16	0.86

Table 14

AUTHENTICITY RELATED TO AGE

AGE	<u>n</u>	Mean	<u>t</u> value	Probability
< 30 Years	8	3.23		
> 30 Years	28	3.48	-1.45	0.15
< 40 Years	22	3.42		
> 40 Years	14	3.43	-0.06	0.94

Table 15

UTILIZATION OF INFORMATION RELATED TO AGE

AGE	<u>n</u>	Mean	<u>t</u> value	Probability
< 30 Years	8	3.64		
> 30 Years	28	3.48	-1.29	0.20
< 40 Years	22	3.78		
> 40 Years	14	4.02	-1.18	0.24

Table 16

UTILIZATION OF RESOURCES RELATED TO AGE

AGE	<u>n</u>	Mean	<u>t</u> value	Probability
< 30 Years	8	3.96		
> 30 years	28	4.21	-1.39	0.17
< 40 Years	22	4.07		
> 40 Years	14	4.29	-1.47	0.14

Table 17

UTILIZATION OF SOCIAL SUPPORT RELATED TO AGE

AGE	<u>n</u>	Mean	<u>t</u> value	Probability
< 30 Years	8	4.09		
> 30 Years	28	4.28	-1.26	0.21
< 40 Years	22	4.20		
> 40 Years	14	4.30	-0.77	0.44

Table 18

DEMONSTRATION OF AUTONOMY RELATED TO AGE

AGE	<u>n</u>	Mean	<u>t</u> value	Probability
< 30 Years	8	3.64		
> 30 Years	28	3.95	-1.33	0.19
< 40 Years	22	3.85		
> 40 Years	14	3.93	-0.38	0.70

Table 19

PROVISION OF INFORMATION RELATED TO AGE

AGE	<u>n</u>	Mean	<u>t</u> value	Probability
< 30 Years	8	3.48		
> 30 Years	28	3.42	0.26	0.78
< 40 Years	22	3.42		
> 40 Years	14	3.45	-0.13	0.89

Table 20

PROVISION OF RESOURCES RELATED TO AGE

AGE	<u>n</u>	Mean	<u>t</u> value	Probability
< 30 Years	8	3.08		
> 30 Years	28	3.02	0.23	0.81
< 40 Years	22	3.06		
> 40 Years	14	3.00	0.30	0.76

Table 21

PROVISION OF SOCIAL SUPPORT RELATED TO AGE

AGE	<u>n</u>	Mean	<u>t</u> value	Probability
< 30 Years	8	3.25		
> 30 Years	28	3.15	0.33	0.74
< 40 Years	22	3.15		
> 40 Years	14	3.21	0.25	0.79

Table 22

AUTONOMY ENCOURAGED RELATED TO AGE

AGE	<u>n</u>	Mean	<u>t</u> value	Probability
< 30 Years	8	3.33		
> 30 Years	28	3.19	0.44	0.65
< 40 Years	22	3.24		
> 40 Years	14	3.19	0.20	0.83

An independent t test was conducted on the variables of years of experience and the motivational component of empowerment. Interval data related to years of experience were converted to ordinal data with the groupings being 10 years' or less nursing experience and greater than 10 years of experience. Data analysis indicated a significant difference in the responses related to the motivational component of nursing empowerment with self-efficacy ($p = .03$). There was not a statistically significant difference with self-esteem and authenticity responses; however, the total motivational difference was significant at the $p = .05$ level (see Appendix I).

Table 23

SELF-ESTEEM RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 Years	23	3.36		
> 10 Years	13	3.52	-1.27	0.20

Table 24

SELF-EFFICACY RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 Years	23	3.40		
> 10 Years	13	3.74	-2.14	0.03*

Table 25

AUTHENTICITY RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 Years	23	3.35		
> 10 Years	13	3.57	-1.40	0.16

Table 26

MOTIVATIONAL COMPONENT RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 Years	23	3.37		
> 10 Years	13	3.61	-1.86	0.05*

An independent t test was conducted on the variables of years of experience and the relational component of nursing empowerment, including utilization of information, utilization of resources, utilization of social support and demonstration of autonomy. A statistically significant difference was noted with the relational component of nursing empowerment ($P = .0002$).

Table 27

UTILIZATION OF INFORMATION RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 Years	23	3.65		
> 10 Years	13	4.28	-3.60	0.001*

Table 28

UTILIZATION OF RESOURCES RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 Years	23	3.97		
> 10 Years	13	4.48	-3.80	0.0006*

Table 29

UTILIZATION OF SOCIAL SUPPORT RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 Years	23	4.11		
> 10 Years	13	4.47	-3.07	0.004*

Table 30

DEMONSTRATION OF AUTONOMY RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 Years	23	3.69		
> 10 Years	13	4.21	-2.76	0.009*

Independent t tests were conducted on the variables of years of experience and the relational components of nursing empowerment, including provision of information, provision of resources, provision of social support, and encouragement of autonomy. There was no statistically significant difference noted with these factors.

Table 31

PROVISION OF INFORMATION RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 years	23	3.41		
> 10 Years	13	3.47	-0.32	0.74

Table 32

PROVISION OF RESOURCES RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 Years	23	2.99		
> 10 Years	13	3.11	-0.52	0.60

Table 33

PROVISION OF SOCIAL SUPPORT RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 Years	23	3.14		
> 10 Years	13	3.23	-0.39	0.69

Table 34

AUTONOMY ENCOURAGE RELATED TO EXPERIENCE

Years Exp	<u>n</u>	Mean	<u>t</u> value	Probability
< 10 Years	23	3.19		
> 10 Years	13	3.26	0.07	0.76

The motivational and relational components of nursing empowerment were analyzed utilizing several variables. Significant differences in responses were noted based on years of experience. Differences in responses based on age and educational preparation were not significant.

CHAPTER V

DISCUSSION OF RESULTS

This ex post facto descriptive study was conducted to determine whether nurses' perceptions related to the motivational and relational components of nursing empowerment were significantly different based on educational preparation. There were no previous studies from the literature measuring both the motivational and relational components of empowerment. Also, no previous studies addressed educational preparation as the independent variable. Two major hypotheses and nine related research questions were addressed. Becker is currently conducting a study to measure the relational and motivational components of nursing empowerment from a longitudinal focus. However, data collection for this research is still in progress and unavailable for comparison.

Independent t tests were performed on the motivational component of nursing empowerment, including self-esteem, self-efficacy, and authenticity based on educational preparation. No statistically significant difference ($p < .05$) was noted, therefore the hypothesis and the related research questions were

rejected. Based on these findings, one can conclude that there are no differences in the perception of the clarity of role definition based on educational preparation of this sample. The ADN and BSN prepared nurses in this study did not perceive a difference in the level of effectiveness or the significance or meaning associated with their role.

When drawing the conclusion that there are no differences in the motivational component of empowerment based on educational preparation, several contributing factors should be examined related to these findings. Factors within the academic setting may not lead to a difference in perceptions of the motivational component of empowerment. Perhaps the curriculum, student or faculty expectations, presentation styles, or other factors are similar between ADN and BSN programs, and therefore do not result in a difference in empowerment perceptions. Another factor that may have influenced the findings could be related to role expectations within the work setting. Perhaps, based on job design, management style, reward and recognition systems, or other factors, individuals do not perceive a difference in

self-esteem, self-efficacy, or authenticity. In addition, in concluding that there is no relationship between perceptions of the motivational component of empowerment and educational preparation, a Type II error may have occurred because of the small sample size.

Independent t tests were performed on the relational component of nursing empowerment, including the use and provision of information, resources, social support systems, and autonomy in role performance. No statistically significant difference ($p < .05$) was noted for any aspects, except the use of information ($p = .04$). The hypothesis and all other research questions were rejected. Based on these findings, the conclusion that there are no differences in the perceptions of provision of information, resources, social support, and encouragement of autonomy, and the utilization of resources, social support, and the demonstration of autonomy in the work setting based on educational preparation can be made.

A relationship between use of information and educational preparation was found. If there is a relationship between use of information and educational

preparation, one would also expect to find a difference in responses between provision of information and educational preparation. However, findings were not similar with these two factors. The possibility of the differences being based on chance and a Type I error occurring must be considered. Use of independent t tests for the comparison of results may also contribute to a Type I error. The financial status of the hospital and the philosophy related to use of resources and supplies may also contribute to a Type I error. Concluding that there is a significant relationship between educational preparation and use of resources might indicate that there are differences in ADN or BSN curriculum, such as a focus on economic issues or reimbursement factors.

When drawing the conclusion that there are no differences in the relational component of empowerment based on educational preparation, several contributing factors should once again be considered related to these findings. Factors within the academic setting may not lead to a difference in perceptions of the relational component of empowerment. Perhaps neither ADN nor BSN academic settings focus on use or provision

of information, resources, social support, or autonomy since these factors can vary greatly from organization to organization. Orientation within the work setting may influence individual perceptions associated with the relational component of empowerment. Use of preceptors, mentors, or role models; the length of orientation; and the stability and financial status of the organization may influence individual perceptions related to empowerment. In addition, in concluding that there is no relationship between perceptions of the relational component of empowerment and educational preparation, a Type II error may have occurred because of the small sample size.

The variables of age and length of experience were also examined as factors related to empowerment. There were no differences noted in responses associated with the motivational or relational components of empowerment based on age. Data were analyzed based on two age group divisions: over and under 30 years and over and under 40 years. No significant findings were noted with either age group analysis. Perhaps these findings are not surprising since nurses enter the work force at a variety of ages. The fact that the average

age of the graduate nurse is over 30 may also influence this finding.

There was a significant difference in responses based on length of experience and the overall motivational component of empowerment, with self-efficacy being the strongest factor. There was also a significant difference in responses based on length of experience and all factors in the relational component of nursing empowerment associated with the utilization of information, resources, social support, and autonomy. These findings did not hold true with the provision of information, resources, social support, and autonomy. This may be related to the philosophy and financial status of the organization.

A convenience sample of all part-time and full-time employed RNs in the organization was included in the study to allow for as large a sample size as possible. PRN nurses were excluded from the sample, however, a large number of the RNs employed in this organization fall under the PRN status. Redefining the work status for inclusion in the study could have resulted in a larger sample size.

In discussing the research findings, factors

affecting internal and external validity must be considered. Attempts to control internal validity were addressed through inclusion of both the relational and motivational components of nursing empowerment. In addition, use of a single organization for data collection was chosen since this would eliminate differences based on organizational philosophy, defined role of the nurse, staffing shortages and patterns, support of nursing and other specific organizational variables. The study methodology was described in detail and would allow for easy replication.

Internal validity may have been a problem since no significant differences were noted based on manipulation of the independent variable, educational preparation. Differences in reported perceptions of the motivational and relational components of empowerment were found based on length of experience. Although no differences were noted with age, other factors related to nursing empowerment should be considered. If one examines differences in educational preparation, diploma nurses could be included since they make up a large part of the work force in many organizations. Differences in responses based on the

number of hours worked per week may also be an important factor. Responses based on gender, primary shift worked, participation in determining own schedule, management styles, length of employment of the manager, and administrative support for empowerment strategies may also be factors to consider. Individual organizations may certainly have additional factors within their structure that could influence nursing empowerment. Examination and inclusion of these factors would be important.

Previous knowledge about empowerment may be a factor since many of the participants in the study had indicated previous recent exposure to programs or classes that were related to empowerment, women's issues or oppressed behavior. A closer examination of the focus of the information provided at these programs would provide insight into this variable.

Conclusions from this study may not be applicable to nursing in general. Factors within the organization such as stability, financial status, type of patient population served, personnel management policies, and reward/recognition systems may affect the ability to generalize. Utilizing a random sample selection

process and including a larger sample size would strengthen external validity. Including additional levels of educational preparation, as well as other factors such as shift worked and work status, may assist with the identification of factors associated with nursing empowerment.

Recommendations to Future Researchers

Although previous researchers have addressed components of empowerment separately, findings from this study support examining both relational and motivational factors. A separation of these factors could lead to misperceptions related to empowerment; therefore, it is important for future research to include both factors.

A larger sample size should be used to decrease the likelihood of errors. In addition, including other factors related to staffing patterns and management styles may be helpful. Information related to a recent stressful situation in an individual's work setting or personal life could also be included.

Finally, perhaps nursing empowerment is best measured longitudinally, instead of cross-sectionally.

In measuring empowerment over time, one would have a better feel for the effectiveness of strategies important in promoting nursing empowerment. If one concludes from the findings of this study that perceived levels of empowerment are not different, perhaps the focus should be on the effectiveness of strategies instead. An experimental research design in which one would randomly select nurses to be in either a group where strategies are implemented or a group where no strategies are implemented would show a better picture of factors related to empowerment, which factors can be manipulated, and the resulting outcome of that manipulation.

Implications for Nursing:

The findings from this study are useful to nursing at the student, faculty, staff nurse, nurse manager and nursing administrative levels in both the academic and service settings. Awareness of perceived levels of empowerment at the staff, manager, or administrative level can influence strategies to affect the provision of nursing care. The identification of factors associated with the relational and motivational

components of empowerment over time can allow for the evaluation of the effectiveness of empowering strategies.

Faculty of academic programs may want to examine factors related to nursing empowerment and increase the focus of these variables. Academia and service can collaborate to develop orientation programs that can foster the development of strategies that support empowerment. Use of preceptors, mentors and role models can be key strategies leading to empowerment.

Implications for nursing service are important since a relationship was found between length of experience and factors associated with nursing empowerment. These findings support the importance of retention of employees. Nurse leaders may use these findings to support decisions related to the development of strategies to retain employees, such as recognition and reward systems, job redesign, pay for performance, and clinical advancement systems. Adjustments in starting salaries for individuals with experience may become more important in order to recruit individuals who have stronger perceptions related to empowerment. Clearly, rationale for

involvement of experienced or empowered individuals on committees, with the development of policies, procedures, and standards and implementation of a shared governance style of management can be supported.

The definition of nursing care through empowered employees can influence the professional practice of nursing. Strategies to support and enhance the empowered role of the nurse can lead to benefits for the consumer and the quality of health of those served by nursing.

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Appendix A
RN GROWTH AND DEVELOPMENT SURVEY

The purpose of this survey is to measure your current perceptions about empowerment.

It is not my intent to identify you. In order to maintain your anonymity, please do not write your name anywhere on this form. At no time will this survey be connected with your personnel file and therefore it could never influence your employment status in any way. The data on this survey form will be used only as part of a research project intended to measure nurse empowerment.

Primary researcher: Marnie Killip, RN, BSN, MSN student, Drake University.

1. Please write the last four digits of your social security number on the lines provided as a code number _ _ _ _ .
2. CIRCLE your age group

1. less than 20	4. 41 to 50
2. 21 to 30	5. 51 to 60
3. 31 to 40	6. over 60
3. Write in the number representing the years of nursing experience you have had as an RN/GN _____ .
4. CIRCLE entry level educational preparation.

1. Diploma	5. MSN
2. ADN	6. MS/MN
3. BSN	7. MA
4. BA/BS	8. PhD/D/DNS
5. Indicate your marital status by CIRCLING one item that follows:

1. Single	4. Widowed
2. Married	5. Divorced
3. Separated	
6. Please CIRCLE your current specialty area of nursing:

1. Critical care	5. Oncology
2. Medical-Surgical	6. Psychiatric
3. Mother-Baby	7. Intermediate Care
4. Pediatrics	8. Surgical Services
	9. _____ (fill in please)
7. How long have you worked in this specialty area? _____ .
8. Indicate your length of time as an employee in this hospital: _____ years, _____ months.

9. In the past five years, have you attended a class or other educational program on empowerment, women's studies, oppressed group behavior or minority studies? Please CIRCLE answer.
1. yes 2. no
10. If your answer to question 9 was yes, please list below (1) the name of each program, (2) its length (e.g. one day, a semester, etc.), and (3) the year that you attended it.
(1) (2) (3)
11. Have you attended any of these types of programs more than five years ago? (Please CIRCLE the correct answer.)
1. yes 2. no
12. If your answer to question 11 is yes, please list these programs as well, as above.
(1) (2) (3)

Please write today's date here _____.
Thank you. Now please turn the page.

You are now ready to begin this survey. Please mark the first answer that you think of by CIRCLING only one number for each item using this scale:

- 5 = almost always
 4 = frequently
 3 = fairly often
 2 = only occasionally
 1 = almost never

- | | | | | | |
|---|---|---|---|---|---|
| 1. Think of the last several times you were given credit for something; was it deserving? | 5 | 4 | 3 | 2 | 1 |
| 2. How often in your work do you feel like you have control over the situation at hand? | 5 | 4 | 3 | 2 | 1 |
| 3. How frequently do you think about changing your physical appearance? | 5 | 4 | 3 | 2 | 1 |
| 4. As a nurse, how often do you feel fully competent in coordinating care to meet patients' needs? | 5 | 4 | 3 | 2 | 1 |
| 5. How frequently do you hide your true feelings from others? | 5 | 4 | 3 | 2 | 1 |
| 6. To what degree do you feel comfortable being the center of attention at a social gathering? | 5 | 4 | 3 | 2 | 1 |
| 7. Once you define a personal goal, how often do you achieve it? | 5 | 4 | 3 | 2 | 1 |
| 8. How often do you find yourself complimenting other people? | 5 | 4 | 3 | 2 | 1 |
| 9. How often are you comfortable discussing your strengths and weaknesses with your immediate supervisor? | 5 | 4 | 3 | 2 | 1 |
| 10. To what degree do you assume the leadership role in your work group? | 5 | 4 | 3 | 2 | 1 |
| 11. How frequently do you take a stand on an issue with a peer? | 5 | 4 | 3 | 2 | 1 |
| 12. During the last year, how often were you able to make changes happen in your work life? | 5 | 4 | 3 | 2 | 1 |

5 = almost always
 4 = frequently
 3 = sometimes
 2 = rarely
 1 = almost never

- | | | | | | |
|--|---|---|---|---|---|
| 13. How often are you fearful of failure prior to a project, presentation or test? | 5 | 4 | 3 | 2 | 1 |
| 14. To what extent do you think you stand out among your peers as a talented and knowledgeable professional? | 5 | 4 | 3 | 2 | 1 |
| 15. In your work situation, how often have you felt at a disadvantage among those with whom you work? | 5 | 4 | 3 | 2 | 1 |
| 16. How frequently are you comfortable as a patient advocate? | 5 | 4 | 3 | 2 | 1 |
| 17. In your work, how often do you find yourself relying upon assistance from other nurses in making clinical practice decisions? | 5 | 4 | 3 | 2 | 1 |
| 18. When participating in group activities how often do you volunteer to take the leadership role? | 5 | 4 | 3 | 2 | 1 |
| 19. How often do you debate with yourself and ultimately change your mind regarding an earlier decision? | 5 | 4 | 3 | 2 | 1 |
| 20. How frequently do you discount compliments paid to you by other persons? | 5 | 4 | 3 | 2 | 1 |
| 21. Think of the day-to-day give and take among you and others at the workplace. How often do you find yourself feeling embarrassed? | 5 | 4 | 3 | 2 | 1 |
| 22. How often in your work do you have a day when everything seems to go wrong? | 5 | 4 | 3 | 2 | 1 |
| 23. How frequently are others noticing the particular contributions you make at work? | 5 | 4 | 3 | 2 | 1 |
| 24. Over the past year, how often have you been able to laugh at yourself in the presence of others? | 5 | 4 | 3 | 2 | 1 |

Go on to the next survey, please.

PROFESSIONAL PRACTICE SURVEY

The purpose of this form is to measure the degree of freedom you perceive that you have had in your professional work.

Again, do not write your name on this survey form. Instead, the same code number will be used consisting of only the last four digits of your social security number.

Please write the last four digits of your social security number here _ _ _ _.

INSTRUCTIONS:

You are ready now to begin this survey. Each pair of phrases below indicates a range of five (5) to one(1) for your response. Please read each phrase. Then, on the line between each pair, CIRCLE the number that best describes your normal behavior or tendency. There are no right or wrong answers on this survey. Please do not delete any items; if the circumstance described is new to you, choose the response you believe you would make in a real life work situation. A word of caution: some items are phrased in a negative format; therefore, please read each item carefully before responding;

- | | | |
|---|-------------------|--|
| 1. I actively seek information and feedback daily. | 5 4 3 2 1 | I rarely see the need to solicit information or feedback from others. |
| 2. I do not hesitate to call on others for assistance. | 5 4 3 2 1 | I find it very difficult to ask others for assistance. |
| 3. I often network to share facts and information sources with others. | 5 4 3 2 1 | I feel a need to keep facts to myself and protect my information sources. |
| 4. I appropriately challenge the actions or decisions of other professionals. | 5 4 3 2 1 | I am really unable to speak up to challenge questionable decisions of other professionals. |
| 5. I don't think about the goals, standards, or values of this hospital. | 5 4 3 2 1 | I can readily identify the goals, standards and values of this hospital. |

- | | | |
|--|--------------------------|---|
| <p>6. I am often looking for ways to make more efficient use of my work time.</p> | <p>5 4 3 2 1</p> | <p>I don't think about time efficiency improvements in my work.</p> |
| <p>7. A nurse should look for a mentor when coming to work in a new health care organization.</p> | <p>5 4 3 2 1</p> | <p>A nurse does not need a mentor. I prefer to do things on my own and find my own way.</p> |
| <p>8. I do not hesitate to suggest creative solutions to problems.</p> | <p>5 4 3 2 1</p> | <p>I am careful about making suggestions that are different from the way things have been done.</p> |
| <p>9. By choosing to eat my meals with staff outside my work group, I can make valuable contacts.</p> | <p>5 4 3 2 1</p> | <p>I believe in staying with my coworkers at mealtimes or when otherwise off my own unit.</p> |
| <p>10. A priority in any new job is to learn how to access supplies, equipment, etc, needed in the work.</p> | <p>5 4 3 2 1</p> | <p>I do not think it is a priority to access such materials when starting a new job.</p> |
| <p>11. I have a responsibility to guide my coworkers when they request my help.</p> | <p>5 4 3 2 1</p> | <p>My coworkers should take care of themselves and learn it the way I did.</p> |
| <p>12. I focus a lot on minimizing use of supplies to save money for the patients and the hospital.</p> | <p>5 4 3 2 1</p> | <p>It is not my responsibility to worry about costs to patients or to the hospital.</p> |
| <p>13. My decisions are based on selection of alternatives identified by myself or others.</p> | <p>5 4 3 2 1</p> | <p>My decisions are based upon my "gut-level" feelings.</p> |

14. I know the channels of communication to get information I need. 5 4 3 2 1

I do not know or use the channels of communication at this hospital to get information I need.

15. I have a key responsibility in facilitating patients/family to make informed decisions. 5 4 3 2 1

Physicians and nurses need to make decisions for patients since they can make the most intelligent decisions.

16. I do not hesitate to question systems, goals or standards of the hospital. 5 4 3 2 1

You have to work some place a long time before you dare question systems, goals or standards.

17. My immediate supervisor has the responsibility for seeing that I master all related equipment. 5 4 3 2 1

I must take the initiative to master every piece of equipment related to my job.

18. During a crisis I actively seek and readily accept direct and hands-on assistance. 5 4 3 2 1

If I accept or seek assistance during a crisis, it will appear that I am not a competent nurse.

19. I prefer to focus upon the entire episode of patient care, from arrival at the hospital to departure. 5 4 3 2 1

I like to focus on the many small parts of a patient's care and I consider just one shift at a time.

20. I do not ask nurse coworkers for feedback on my performance. 5 4 3 2 1

I often solicit evaluation of my performance from other nurses with whom I work.

21. I value attending informal hospital activities to establish contacts. 5 4 3 2 1

I see no value in attending informal hospital activities to establish personal contacts.

22. I initiate conversation with the unit director order to gain new information that I need. 5 4 3 2 1 The unit director has to approach me before I am comfortable soliciting new information.
23. I do not hesitate to propose changes in standards of care to my unit director. 5 4 3 2 1 It is not up to me to identify changes in standards of care to my unit director.
24. It is not my job to assure that special supply items needed for my patients are available for the next shift. 5 4 3 2 1 I have a responsibility for assuring that supplies needed for my patients care are available for nurses on the next shift.
25. I take the initiative to implement cost-saving changes in a nursing procedure. 5 4 3 2 1 I do not have to worry at all about finding ways to cut costs in nursing procedures.
26. As medical technology changes, I initiate learning to use all new devices in my specialty area. 5 4 3 2 1 It is the responsibility of the unit director and educator to teach me what I need to know to do patient care on this unit.
27. Change of shift report is taking thirty-five minutes; the unit director should really do something about that. 5 4 3 2 1 I need to take action to cut down on the thirty-five minute change of shift report on our unit.
28. It is my responsibility to help develop and modify patient care policies and procedures. 5 4 3 2 1 The management staff or clinical are in control of patient care policies in this hospital.

29. I am really not interested in being a preceptor to a new staff member. 5 4 3 2 1 I value the opportunity to be a preceptor to new staff members on my unit.
30. When my primary patient is not responding well to my plan of care, I do not hesitate to consult with other nurses. 5 4 3 2 1 I hesitate to consult with other nursing staff when my patient is not responding well to my plan of care because they may criticize.
31. I must do my part to create and maintain supportive environment on my unit. 5 4 3 2 1 It is the unit director's job, not mine to create a supportive work environment.
32. I do not appreciate receiving advice from co-workers regarding clinical problems. 5 4 3 2 1 I use the advice of others in my clinical problem-solving and I value receiving it.
33. During a code, I was happy to have someone help me find drugs in the code cart. 5 4 3 2 1 I felt like an incompetent when my coworker began showing me where drugs were stored during a code.
34. I would not administer a contraindicated drug despite pressure from an angry doctor. 5 4 3 2 1 I'd question a doctor's order for a drug contraindicated for my patient, but I'd give it if he said it was OK.
35. If indicated I'd proceed with referrals for homecare without waiting for a doctor's order. 5 4 3 2 1 I would not consider proceeding with any home care referrals unless the doctor gave me an order to do so.

36. Even if the patient's doctor is in surgery, I'd not hesitate to call him on my patient's behalf to question a prescription.

5	4	3	2	1
---	---	---	---	---

If the doctor was in surgery, I'd wait until later to call him on a prescription regardless of my patient's wishes.

37. I wouldn't have the patient sign the consent, if he seemed at all uncertain about wanting surgery.

5	4	3	2	1
---	---	---	---	---

If the surgeon had visited the patient preoperatively, I'd encourage him to sign the consent without delay or further discussion.

38. I would urge administration to try a new system, especially if research supports the system.

5	4	3	2	1
---	---	---	---	---

I'm uncomfortable talking to persons from administration about my suggestions, even if they are based upon research.

Please continue on to the last section of this questionnaire.

SURVEY OF PROFESSIONAL PRACTICE ENVIRONMENT

The purpose of this survey is to assess the current working environment at your hospital. For each of the items below, mark on the line at the left, the number of the first answer that comes to mind using the scale shown below. Please avoid writing your name anywhere on this form.

- 5 = almost always
- 4 = frequently
- 3 = sometimes
- 2 = rarely
- 1 = almost never

- ___ 1. How frequently does your immediately supervisor give you specific feedback on your performance?
- ___ 2. What's the usual frequency of your ready access to the supplies and materials needed in your work?
- ___ 3. How often does a manager act as your sponsor when you need help to achieve a goal?
- ___ 4. To what degree does your job allow you to make discretionary decisions about your clinical practice?
- ___ 5. How much of the time is nursing knowledge or expertise rewarded at your hospital?
- ___ 6. How often is financial support provided for the bonafide needs of you and your coworkers?
- ___ 7. To what extent is networking encouraged for nurses?
- ___ 8. To what degree do you think nursing jobs are designed to focus on whole tasks, rather than separate functions?
- ___ 9. How often does the hospital provide support to you in the acquisition of new knowledge or skills?
- ___ 10. What is the usual frequency that equipment and technology, needed in your work, are provided to you?
- ___ 11. To what degree does your immediate supervisor relate to you as an adult, and in a caring manner?
- ___ 12. How often, in your opinion, is the work of the nurse valued as significant in this organization?

- 5 = almost always
- 4 = frequently
- 3 = sometimes
- 2 = rarely
- 1 = almost never

- ___ 13. To what extent have your performance appraisals contained recognitions for your medical/nursing knowledge?
- ___ 14. Consider the different kinds of support persons clinical nurses need in their work; how frequently are such key support persons available to you?
- ___ 15. How frequently does your manager offer problem-solving advice without mandating it?
- ___ 16. How often can you depend on your immediate supervisor to help you out through "red tape"?
- ___ 17. To what extent do the hospital leaders encourage nurses to honestly evaluate hospital or nursing standards, goals or systems?
- ___ 18. How often do you feel adequate educational sessions are available pertaining to new equipment, products or systems?
- ___ 19. To what degree do you have expert assistance available to you during a clinical crisis?
- ___ 20. How often do hospital leaders recognize and reward the innovative activities of nurses in this hospital?
- ___ 21. In your opinion, how frequently does your nursing manager assist you in gaining access to the information you need?
- ___ 22. To what extent are supplies and material resources available for patient care activities?
- ___ 23. How frequently do you and your coworkers receive mentoring to support your continuing growth and development?
- ___ 24. To what degree does the care-delivery system in your hospital encourage you to make decisions that affect your nursing practice?
- ___ 25. When you master new knowledge and skills, how often do you receive appropriate recognition?

5 = almost always
4 = frequently
3 = sometimes
2 = rarely
1 = almost never

- ___ 26. In the event that new equipment or products are needed on your unit, how frequently are they purchased?
- ___ 27. How often are activities or events scheduled which encourage nurses to interact with other healthcare professionals outside the work unit?
- ___ 28. To what extent do work assignments on your unit encourage nurses to manage cases, rather than tasks?
- ___ 29. In your opinion, how often are resources available to you to assist in your acquisition of new knowledge?
- ___ 30. To what degree do available technical systems and equipment support your day to day work?
- ___ 31. How often does your immediate supervisor relate to you in a caring, adult to adult manner?
- ___ 32. To what extent do others in the organization place adequate value on the work of the nurse?
- ___ 33. How frequently does your daily work give you opportunities to apply your nursing knowledge?
- ___ 34. How often are important support services and staff members available to you when you need them?
- ___ 35. How frequently has your manager offered advice to assist you in clinical problem-solving while giving you the freedom to choose or reject the advice?
- ___ 36. When confronted with bureaucratic "red tape" in your work, how often has a manager assisted you in overcoming these delays.
- ___ 37. How often have you noticed hospital leaders encouraging nurses to revise established standards, goals or systems?
- ___ 38. To what extent are nurses satisfactorily trained in using technology and equipment required in their work?
- ___ 39. During "codes" or other crises, how often do you have expert assistance available to you?

- 5 = almost always
- 4 = frequently
- 3 = sometimes
- 2 = rarely
- 1 = almost never

- _____ 40. How frequently have you known hospital leaders to recognize and reward creative ideas and activities suggested by staff nurses?
- _____ 41. How much of the time does your immediate supervisor provide guidance to you in a caring manner?
- _____ 42. In your observation, how frequently are new nurses mentored and supported by preceptors?
- _____ 43. How often, in your opinion, does your immediate supervisor relate to you in an adult to adult way?

YOU HAVE REACHED THE END OF THE SURVEY. THANK YOU FOR YOUR HELP!

Appendix B

COVER LETTER/INFORMED CONSENT FORM

Dear Colleague,

Quality of the work life of nurses deserves special attention. We have entered an era of shortages of nurses in all areas of nursing practice, as well as decreasing enrollments of candidates in many nursing programs across our nation.

You are being invited to participate in an important research study. You will fill out three questionnaires. Instructions will be provided to you with each questionnaire. Risks are considered minimal in this kind of research. There are no risks whatsoever to your employment status if you prefer not to participate. Since you are important to this research, I hope that you will wish to participate.

Your signature below will give the researcher the opportunity to analyze your scores along with those of other nurses. During the course of this study, all information you provide will be kept confidential. The questionnaires will be handled anonymously. You will write on the forms only the last four digits of your social security number as a code number, not your name. After signing this consent form, you will return it separately from the questionnaires. You will return the questionnaires in the attached, sealable, confidential envelope. The only data that will be released or published will be grouped data related to hospital findings. The results of this research will be available upon request.

Please take a few minutes to complete the attached material and sign the consent form at the bottom of this page. The completed forms should be returned to the office of Becky Harris, where the researcher will collect the sealed envelopes. The deadline date is December 28, 1990.

In summary, your participation is voluntary and you are free to withdraw from this study at any time. You will also be free to ask questions about this study by contacting the researcher below.

Marnie Killip, RN, BSN
Drake University
(515) 233-2116

Your signature

today's date

Appendix C

Dear Colleague,

Recently you were asked to complete and return a research questionnaire addressing the quality of work life of nurses. Your input is important in this research. If you want your responses to be included in the study and have not completed and returned the questionnaire, please take this opportunity to do so. You may contact the office of Becky Harris if you need another copy of the questionnaire and consent form. Please return the completed form to the office of Becky Harris by January 14, 1991. If you have questions about this study feel free to contact me. Thank you.

Marnie Killip, RN, BSN
Drake University Graduate Student
(515) 233-2116

APPENDIX D

MOTIVATIONAL COMPONENT OF NURSING EMPOWERMENT (GDS SURVEY)

SELF ESTEEM

Self Image
Self Worth
Self Confidence
Impression Management

Survey Questions

Question 3
Question 6
Question 8
Question 9
Question 11
Question 15
Question 19
Question 21
Question 24

SELF EFFICACY

Change Agent
Control Over Situation
Role Competency
Autonomy

Survey Questions

Question 2
Question 4
Question 7
Question 12
Question 16
Question 17
Question 18
Question 22

AUTHENTICITY

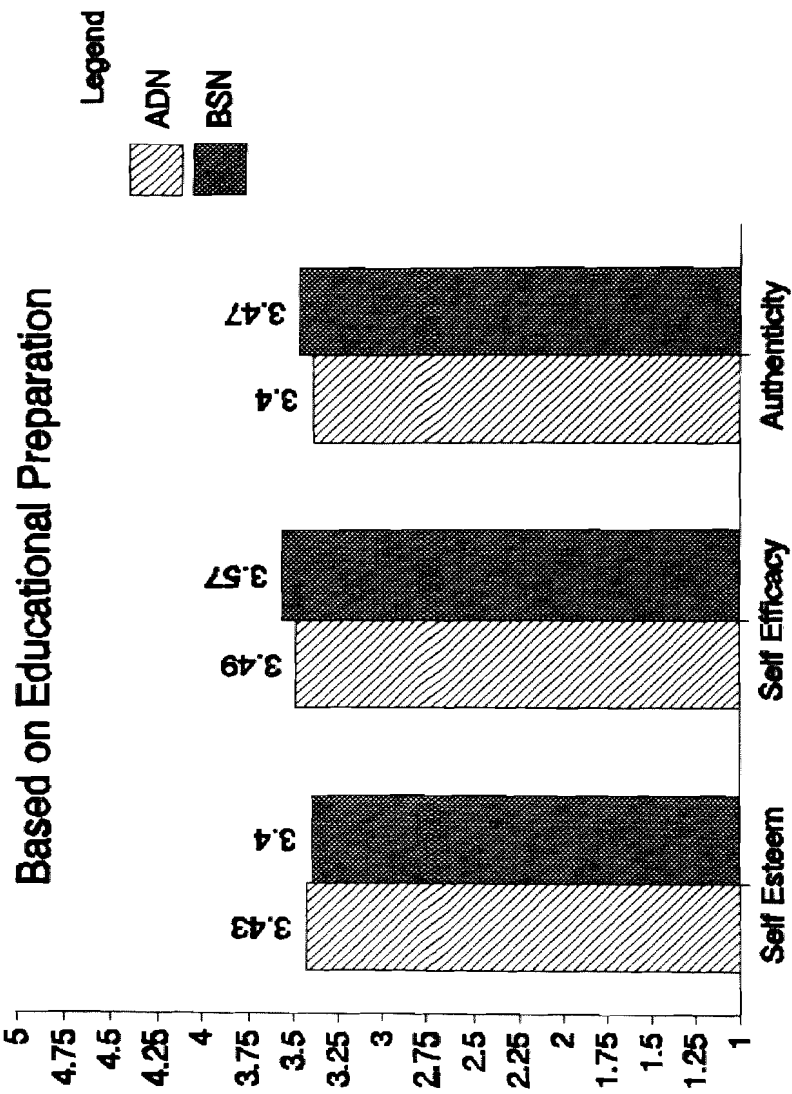
Significance to Others
Self Belief
Recognition by Others
Self Disclosure

Survey Questions

Question 1
Question 5
Question 10
Question 13
Question 14
Question 20
Question 23

Source: Jeanine Becker

MOTIVATIONAL COMPONENT OF EMPOWERMENT



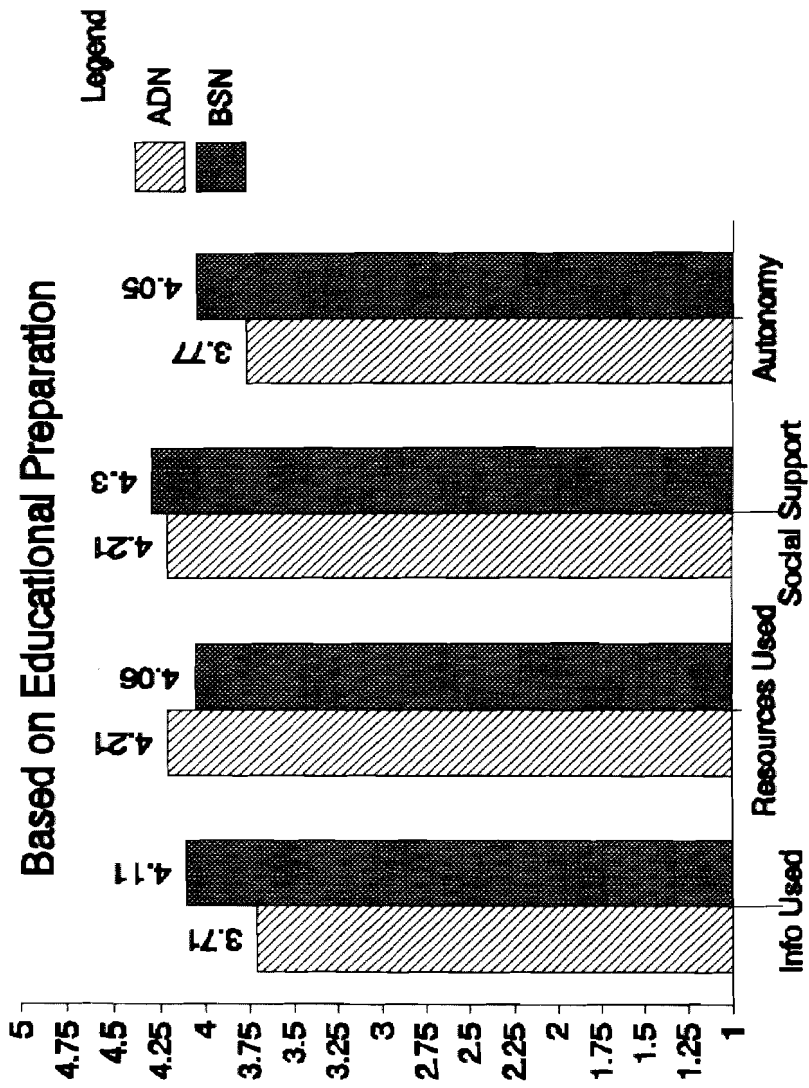
APPENDIX F
RELATIONAL COMPONENTS OF SELF ESTEEM: USAGE (PP SURVEY)

GAINS/USES INFORMATION	USES RESOURCES FROM ENVIRONMENT	BUILDS/USES THE SUPPORT	DEMO AUTONOMY IN ROLE PERFORMANCE
Seeks info and feedback	Access material supplies needed	Forms political alliances with sponsors	Makes approp indep decisions
Id. with org. goals, standards and values	Seeks/max. financial support for pt, self, unit, dept	Networks to share info and resources	Focuses on whole tasks and contiuity in managing a case
Uses informal means to get info	Masters equip and tech systems	Guides others in need upon request	Appro challenges decisions of other healthcare providers
Shares info approp with others	Max use of time in professional practice	Uses problem solving advice in decision making	Facilitates pt/ family in making informed decision
Questions goals, systems or standards approp	Calls upon approp persons for assistance	Seeks accepts assistance in crisis situation	Suggests/imp creative and innovative prob resolution
Survey Questions Q1 Q4 Q15 Q19 Q21 Q22	Survey Questions Q5 Q9 Q11 Q16 Q23 Q24 Q25	Survey Questions Q2 Q3 Q6 Q8 Q10 Q13 Q17 Q20 Q28 Q29 Q30 Q31 Q32	Survey Questions Q4 Q8 Q13 Q15 Q19 Q20 Q28 Q34 Q35 Q36 Q37 Q38

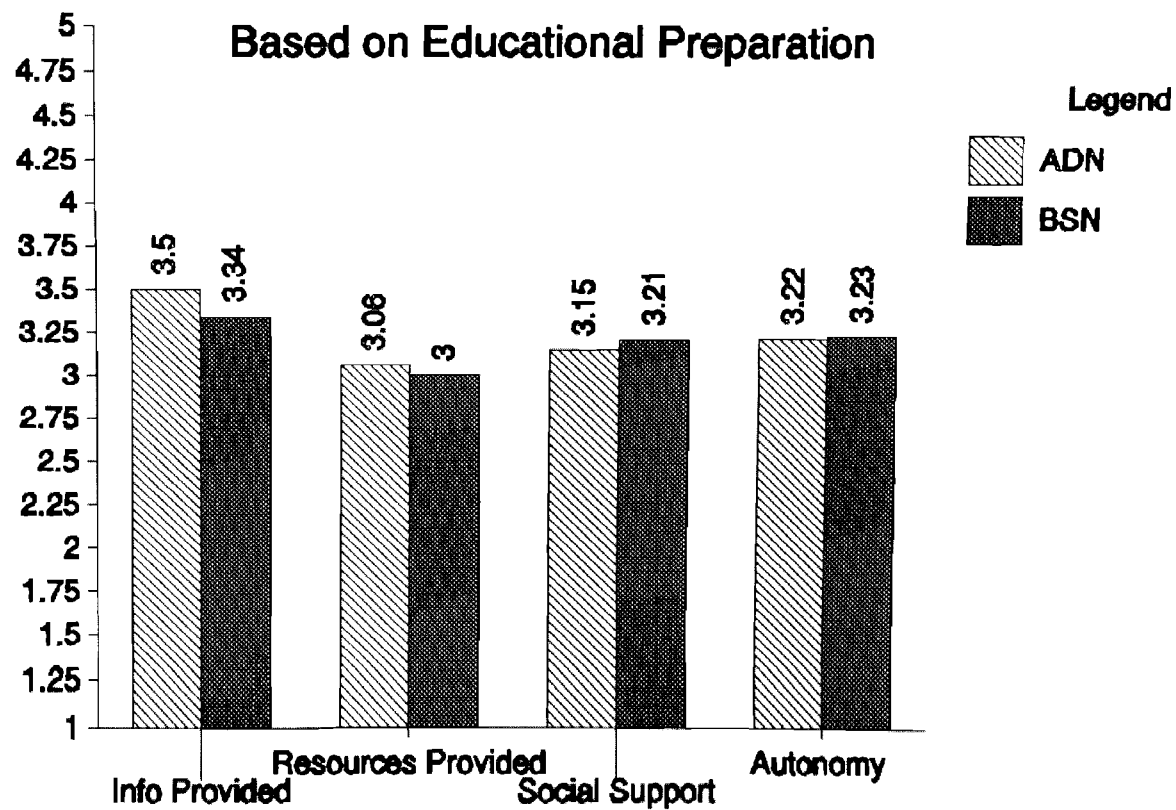
RELATIONAL COMPONENT OF NURSING EMPOWERMENT: PROVISION (PPE SURVEY)

PROVISION OF INFORMATION	PROVISION OF RESOURCES	SOCIAL SUPPORT	ENC AUTONOMY IN ROLE PERFORMANCE
Sup assists in accessing info, includ specific feedback	Sup assists in accessing supplies and materials	Sup staff sponsor/mentor subordinate staff	Job design enc nurse to judgements that affect practice
Knowledge rewarded in org	Financial supp is provided	Networking enc/rewarded	Job design focus on whole task
Support syst assist in knowledge acquisition	Equip and tech systems are appropriate to work	Sup provides guidance in caring/adult manner	Value and significance given to role of nurse in org
Job design integrates appl of knowledge	Key support staff are provided	Problem solving advice is given not mandated	Sup approp cut through "red tape" for staff
Critique of goals, standards and systems enc	Staff educated on use of materials, equip	Expert assist is provided during crisis	Creative decisions and actions rewarded
Survey Questions Q1 Q4 Q5 Q8 Q13 Q17 Q21 Q33 Q34	Survey Questions Q2 Q6 Q10 Q14 Q18 Q22 Q26 Q27 Q29 Q39	Survey Questions Q3 Q7 Q11 Q15 Q19 Q23 Q27 Q31 Q40 Q42	Survey Questions Q9 Q12 Q16 Q20 Q24 Q25 Q28 Q32 Q35 Q36 Q41 Q43 Q37 Q38

RELATIONAL COMPONENT OF EMPOWERMENT

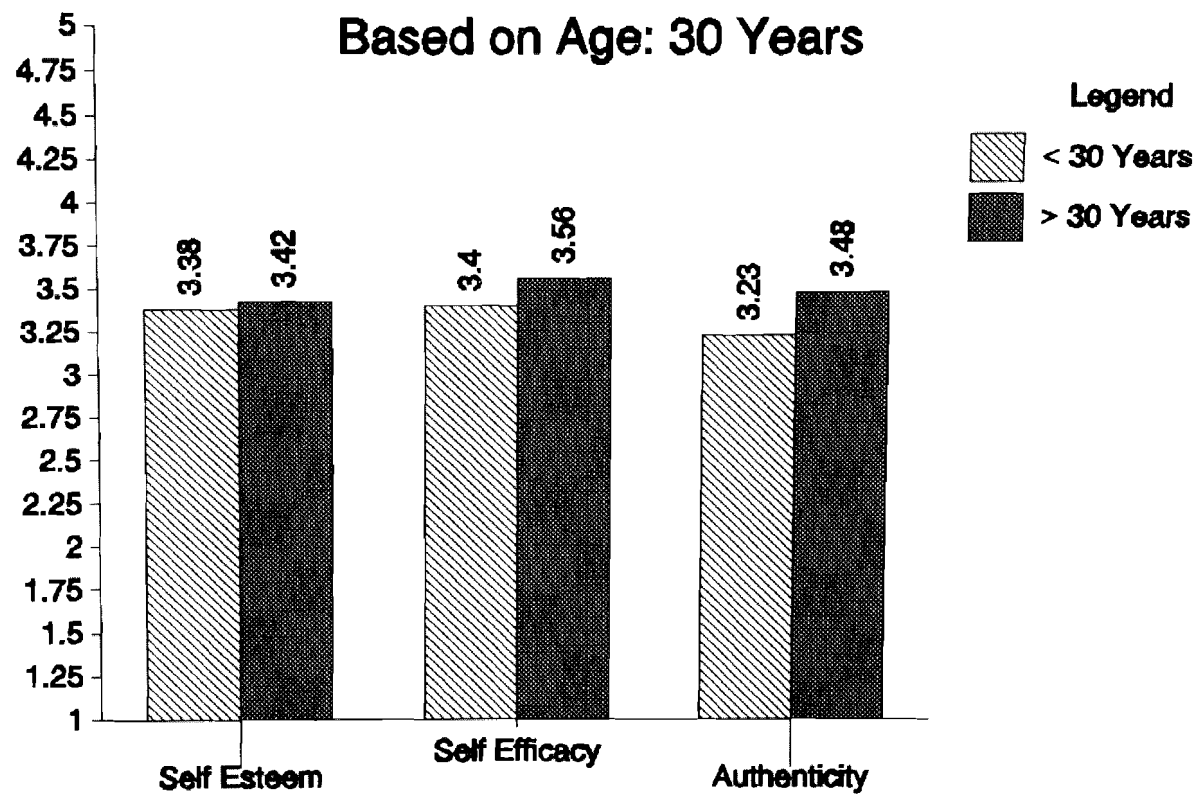


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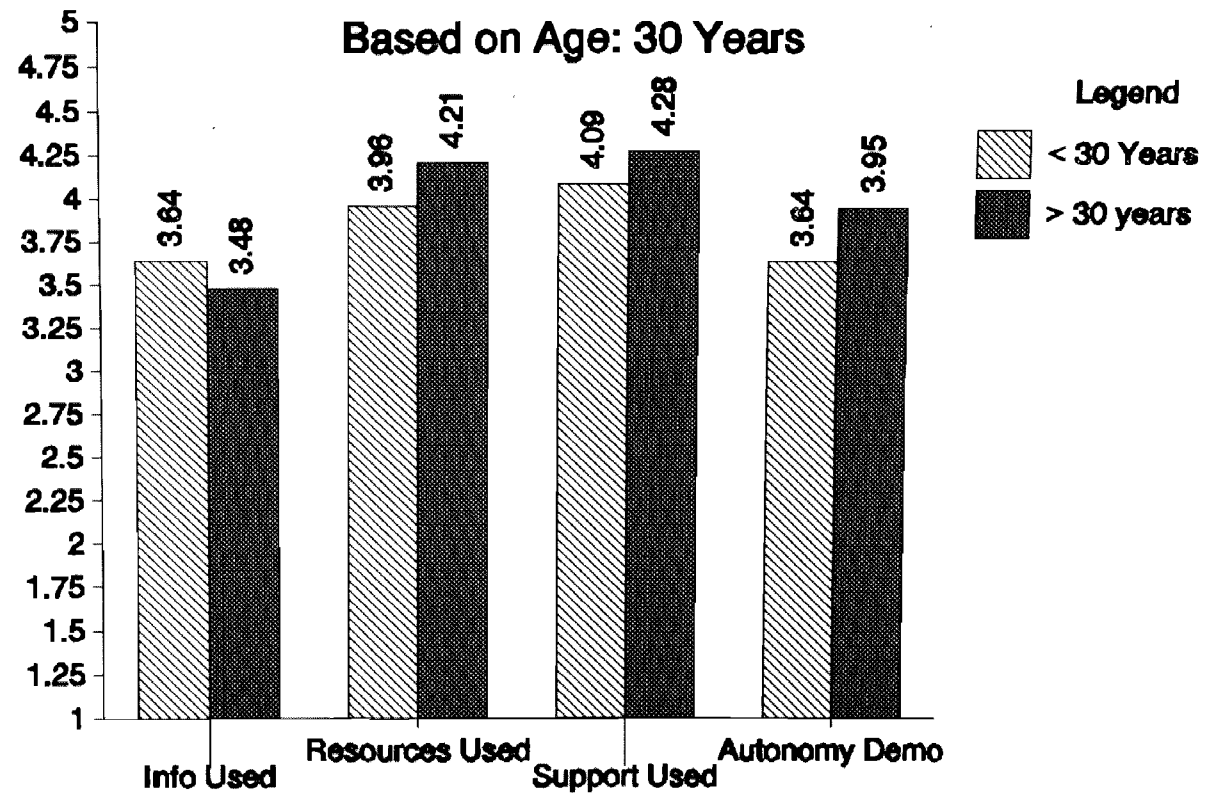


MOTIVATIONAL COMPONENT OF EMPOWERMENT

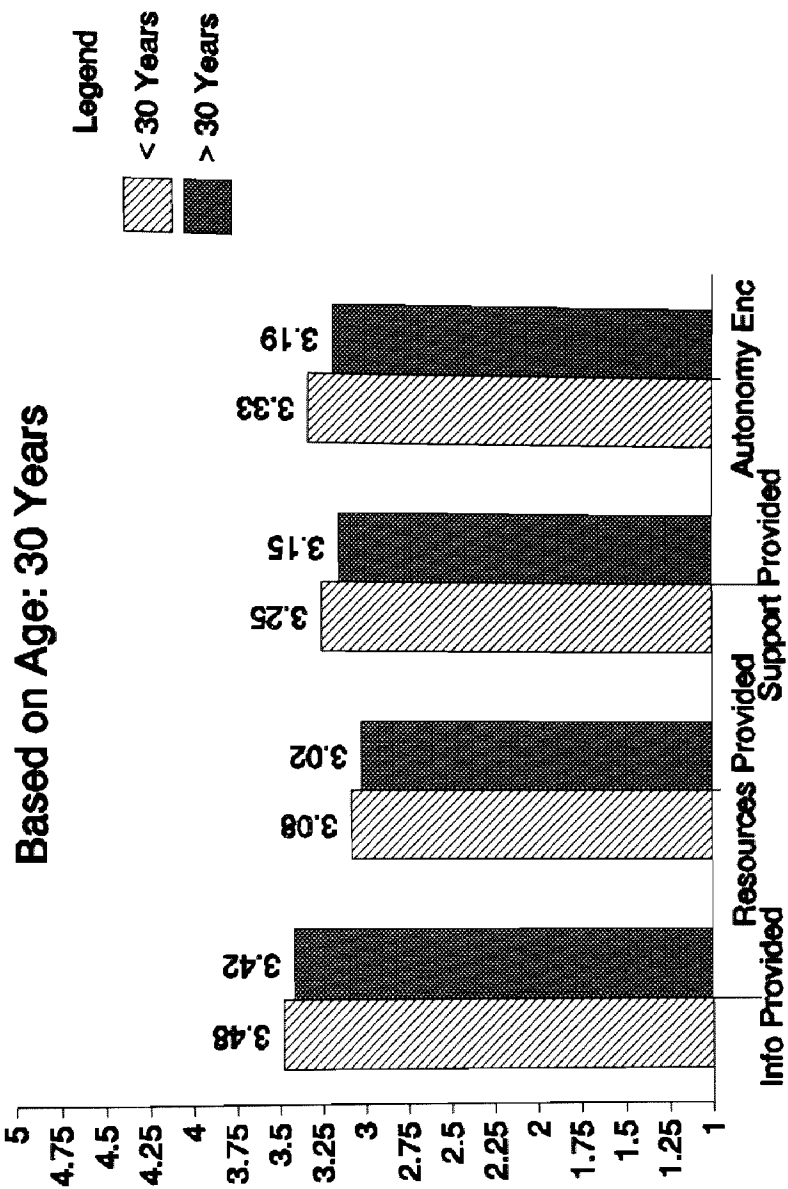
Based on Age: 30 Years



RELATIONAL COMPONENT OF EMPOWERMENT

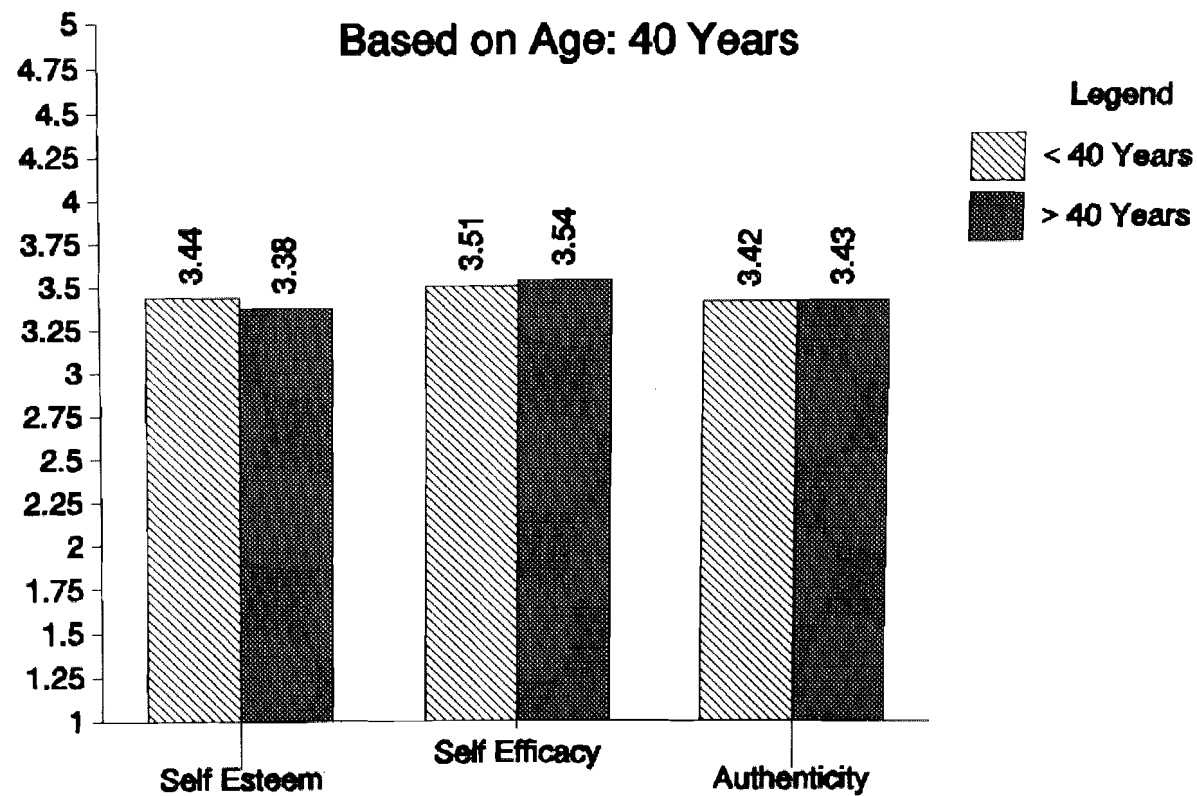


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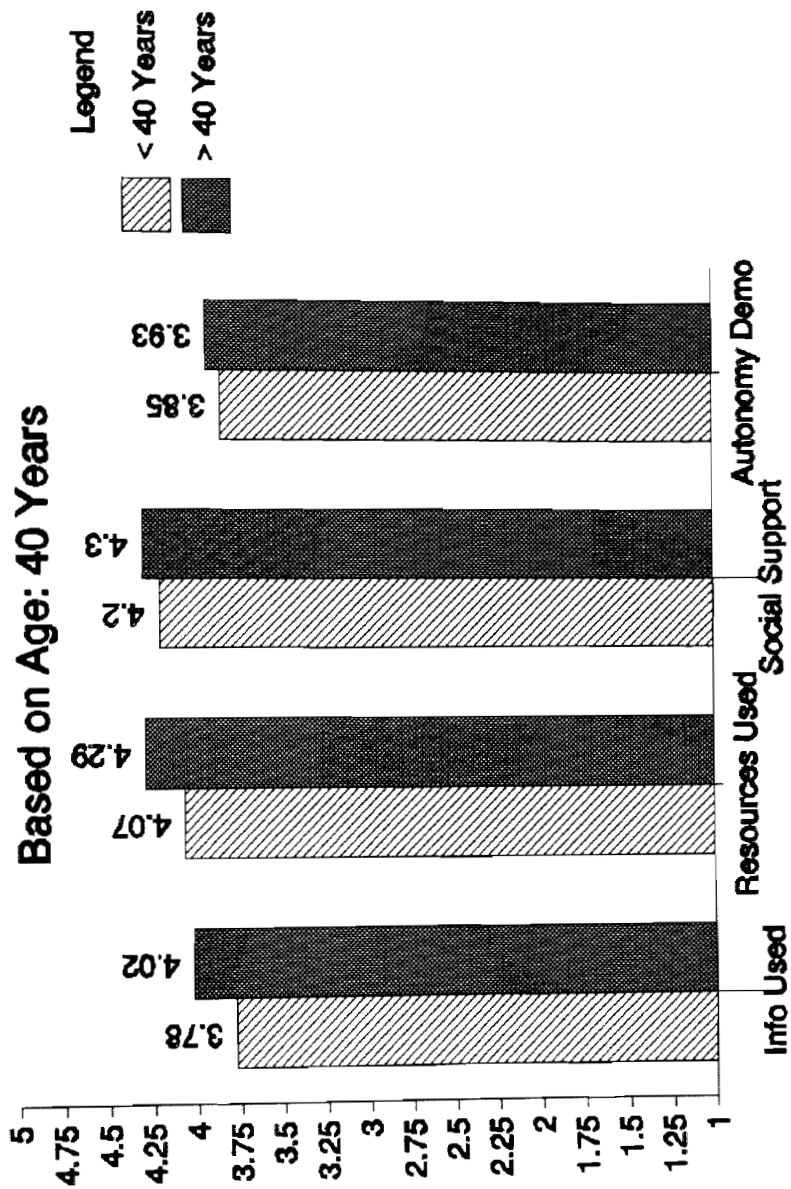


MOTIVATIONAL COMPONENT OF EMPOWERMENT

Based on Age: 40 Years

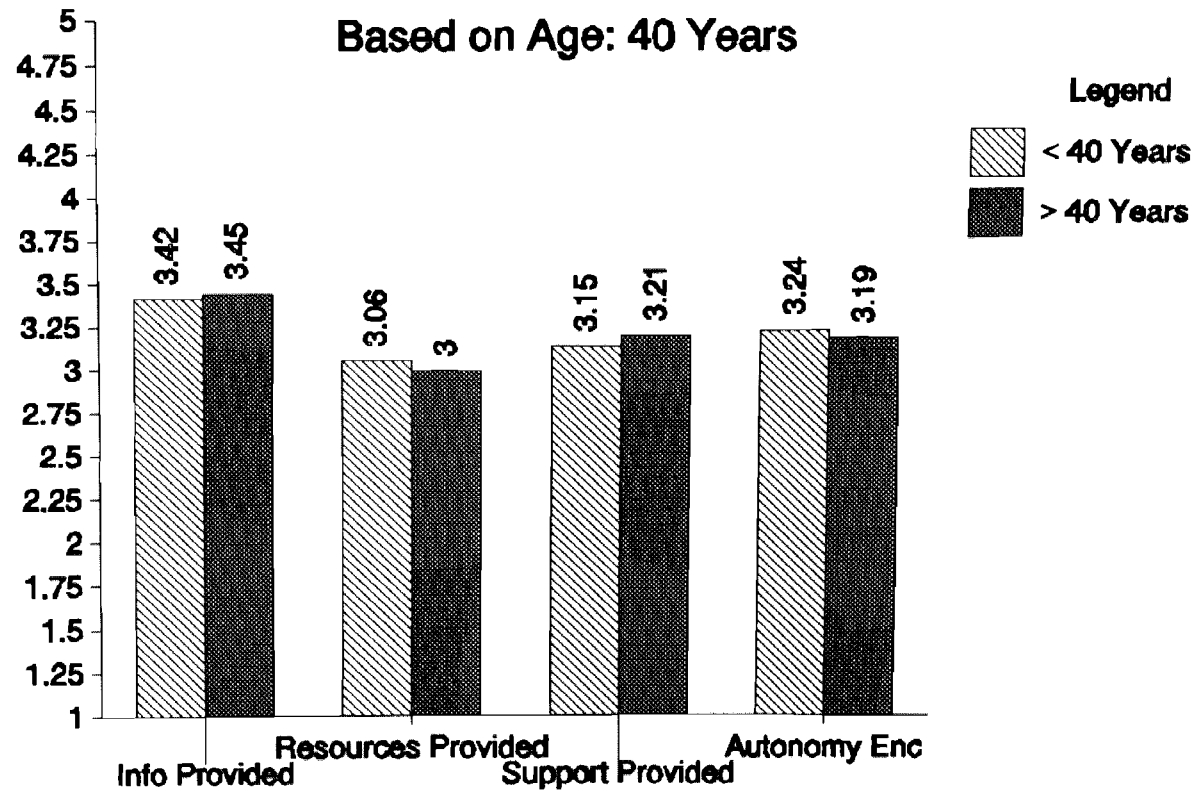


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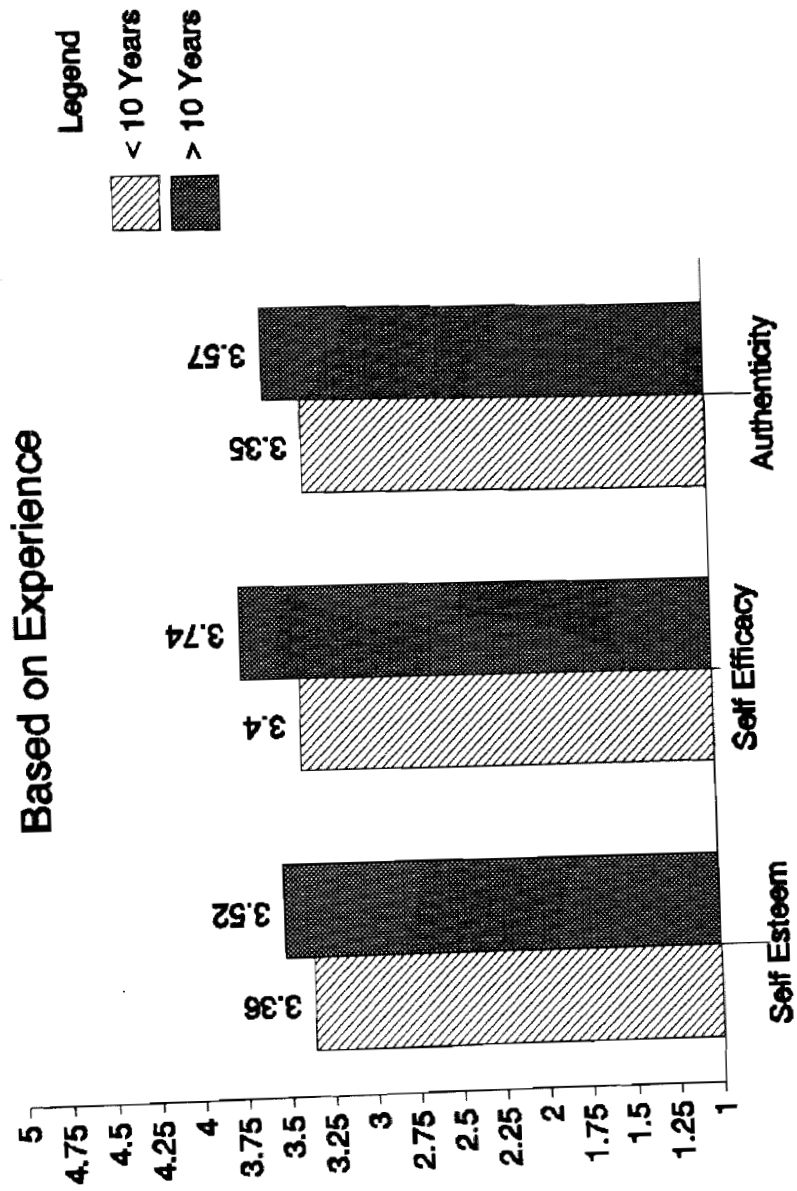


RELATIONAL COMPONENT OF EMPOWERMENT

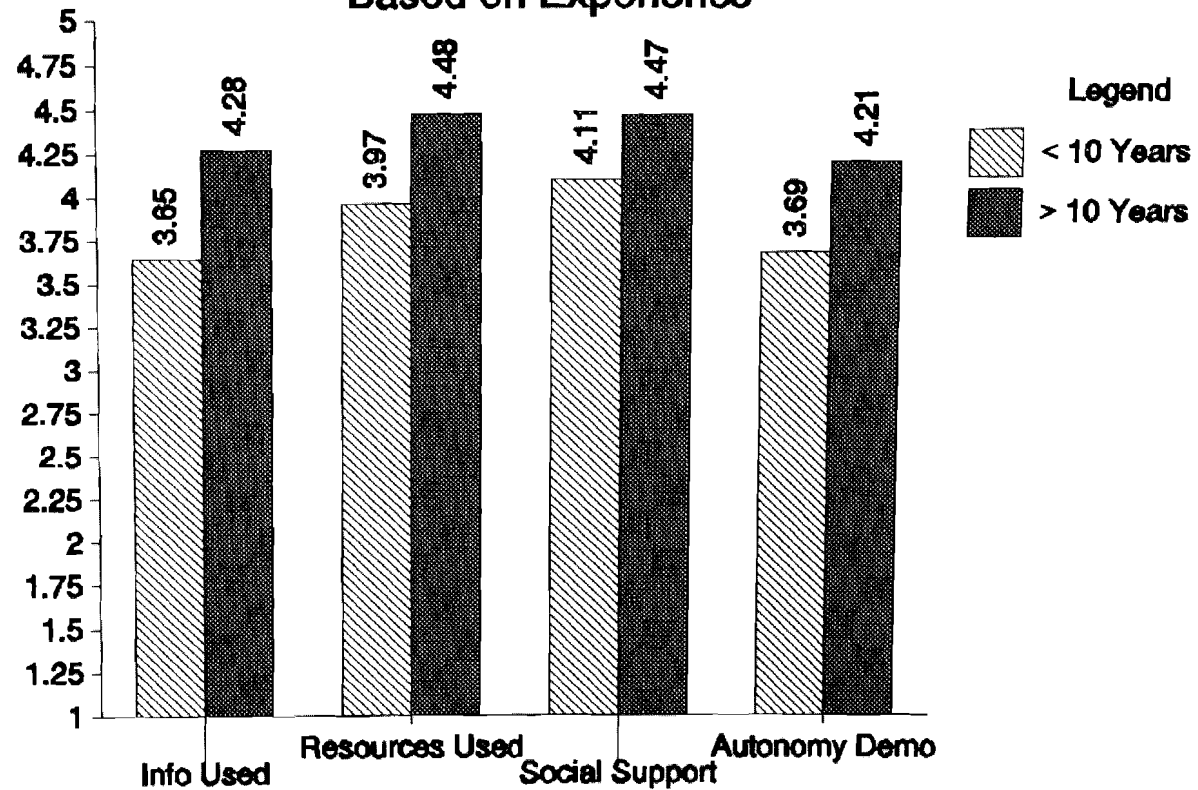
Based on Age: 40 Years



MOTIVATIONAL COMPONENT OF EMPOWERMENT



RELATIONAL COMPONENT OF EMPOWERMENT Based on Experience



RELATIONAL COMPONENT OF EMPOWERMENT

